STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING ______ B. WING ______	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 24 - 28, 2011 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Survey team: Donna Downs, RN, TC Brenda Buroker, RN Deborah Barth, RN Lois Corbin, RN Census bed type: 04 SNF 74 SNF/NF 78 Total Census payor type: 13 Medicare 49 Medicaid 16 Other 78 Total Stage 2 sample: 44 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/04/11	F 000	**F 151** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all residents who are eligible to vote do in fact have the opportunity to vote in elections. Going forward all residents who are eligible to vote will be able to vote. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who are eligible and have a desire to vote have the potential to be affected by this finding. The new Activity Director has been educated as to her role in making certain all arrangements and documentation is completely correctly and timely so that residents will be able to vote in any upcoming elections. The facility has contacted the appropriate polls personnel for the district in which the facility is located so that they can work closely with them in the future for voting participation. The Activity Director will document	
F 151 SS=C	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 151		

RECEIVED
FEB 24 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

approved 03-11-11 RL
An 2nd Req 03/04/11 RLemon

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE HFA/RN — (X6) DATE 02-23-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 1 The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were afforded their right to vote in the most recent election (November 2010). This had the potential to affect all 78 residents residing in the facility. Findings include: During interview of the resident council president on 1/26/11 at 10:30 a.m., she indicated residents were not given the opportunity to vote in the most recent election and indicated it was terrible because it "was an important election." The resident council president indicated the activity director was new and she didn't know what happened. She indicated the previous activity director left abruptly, so she didn't know if it was just an oversight. The Activity Director was interviewed on 1/27/11 at 9:30 a.m. She indicated she had been in the position since October and she wasn't sure how the voting worked. She indicated she wasn't sure how it was set up before she came, but she did get two complaints about it. The Activity Director indicated she wasn't sure if or how it was set up for people to come in and assist residents to vote. The resident council minutes were reviewed on 1/27/11 and there was no indication a discussion was held during the 2010 year regarding the residents' right to vote and/or making	F 151	contacts with these people prior to any election. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the importance of a resident being allowed to vote in all elections was reviewed. The role of the Activity Director was explained as related to coordinating the voting. A consulting Activity Director came to the facility and educated the facility's Activity Director on the voting process in long-term-care facilities. This consultant and the Administrator will monitor all elections going forward. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** The monthly Quality Assurance meetings any upcoming elections will be discussed. The Activity Director will be reminded to initiate timely voting preparation. Progress will be checked each meeting to assure voting can take place. **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 2 arrangements for residents to exercise their right to vote.	F 151		
F 153 SS=C	3.1-3(a)(1) 483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents were aware of their right to review their medical record. This had the potential to affect all 78 residents residing in the facility. Findings include: During interview of the Resident Council President on 1/26/11 at 10:30 a.m., she indicated she was not aware of her right to examine her medical record. She also indicated the right to view medical records had never been brought up in a resident council meeting. During interview of the Activity Director on 1/27/11 at 9:30 a.m., she indicated she did facilitate resident council meetings and took the minutes	F 153	**F 153** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that residents are made aware of their rights. This includes but is not limited to the right to view/access or purchase their medical records. Currently the Resident Council President is aware of this right. Also, going forward at all Resident Council Meetings there will be a designated discussion of Resident Rights in general (as part of the agenda) with more specific information on any right which is of a concern of there is a question regarding. A copy of Resident Rights is given to residents on admission. Resident Rights are posted in the facility. A new copy of Resident Rights was given to each resident since the survey. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 153	Continued From page 3 for the meetings. She indicated they had never discussed their rights as citizens and residents in the facility. She indicated they "haven't discussed rights at a meeting; might bring up something related to a concern, like their right to choose, but they hadn't actually reviewed all the rights of residents," including the right to have access to their clinical records. The resident council minutes were reviewed on 1/27/11. There was no indication resident rights had been discussed/reviewed during the 2010 year. 3.1-4(b)(1)	F 153	***practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. As stated previously, a copy of the Resident Rights is given to the resident/family on admission. A copy is posted in the facility. A copy has been given to each resident since the survey. At the Resident Council Meetings going forward there will be a specified agenda topic dedicated to Resident Rights. They will be discussed in general and then specifically if there is any question or a concern pertaining t one of the rights. This will be documented in the meeting minutes. The Administrator will review and see that all appropriate follow up is completed to the satisfaction of the resident to the greatest degree possible. This will be documented.	
F 156 ;S=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	**F 156** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all residents are properly informed of their rights, rules, services and charges for services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 6 ombudsman and/or the state survey and certification agency, including how to file a complaint. This had the potential to affect all 78 residents residing in the facility. B. Based on interview and record review, the facility failed to ensure notification for non-coverage of Medicare services was provided to 4 of 4 Medicare beneficiaries discharged in the last 6 months who were reviewed for required discharge from skilled service information. (Residents #14, 59, 82 and 80) Findings include: A. During interview of the Resident Council President on 1/26/11 at 10:30 a.m., she indicated she was unaware how to contact the ombudsman or the state survey and certification agency. She indicated she didn't know how to lodge a complaint with them and also indicated this had not been discussed at the resident council meetings. The resident council minutes were reviewed on 1/27/11. There was no indication information had been discussed at the 2010 meetings regarding the ombudsman and/or how to contact the state survey and certification agency or how to lodge a complaint with them. During observations on 1/26/11 and 1/27/11, there was no information posted in the facility regarding information on how to apply for and use Medicare and/or Medicaid. A small frame in the foyer area contained telephone numbers for Medicare and Medicaid, but there was no additional information available. This small frame	F 156	was discussed. Further, the fact that the Social Services Director will monitor these postings weekly was shared. Also, the fact that residents must be informed properly and timely and with specifics when skilled care is to be discontinued was reviewed. Any staff who fail to comply with points of the in-service will be further educated and/or progressively disciplined as appropriate. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitorings of required posted information will be reviewed. Also, copies of the skilled services discontinued letters will be reviewed for accuracy and timeliness and completeness. Any concerns will be addressed. If necessary an action plan will be written by the Administrator and monitored weekly until resolution. **Completion Date: 02/27/11**	

F 153 Continued

Element #3

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

At an all in-service held Feb 15, 2011, the necessity of observing Residents Rights was reviewed. The Resident Rights listing was reviewed. The fact that residents have a right to view their record was shared. The process to do this was discussed. Any staff who fail to perform their role in seeing that Resident Rights are always practiced will be further educated and progressively disciplined as appropriate.

Element #4

How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date

At the monthly Quality Assurance meetings the results of Resident Council Meeting minutes will be discussed to see that all concerns about Resident Rights have been properly explained and addressed. Any pattern will be identified. If necessary, an action plan will be written by a committee appointed by the Administrator. The plan will be reviewed weekly until resolution.

Completion Date: 02/27/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156	This includes but is not limited to written information regarding how to apply for and use Medicare/Medicaid being prominently displayed in the facility. Also displayed prominently are the numbers for the Ombudsman and/or State Survey and Certification Agency including how to file a complaint. Residents 14,59 and 80 have had explanation given more specifically as to why skilled services were discontinued. Resident 82 has been discharged. The Activity Director has been educated on how to contact the Ombudsman and the State Survey and Certification Agency and how to lodge a complaint. This has been discussed in Resident Council and is now part of the agenda. As stated prior, information on how to apply for Medicare/Medicaid is prominently posted. Also, the toll free number for the Indiana State Department of Health complain line is prominently posted. Additionally, the facility is currently notifying the residents two days prior to skilled services ending using a proper form which is filled out completely, accurately and with specific reasons listed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 5 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: A. Based on observation, record review, and interview, the facility failed to ensure written information regarding how to apply for and use Medicare and/or Medicaid was prominently displayed in the facility and failed to ensure residents were aware of how to contact the	F 156	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Going forward the Social Service Director will monitor weekly for al proper postings as to Medicare/Medicaid application process and local and toll free numbers to the Ombudsman and the Indiana State Department of Health to lodge a complaint. Further, the Social Service Director sees' that proper letters are issued timely and accurately with specifics, as to why skilled services are to be discontinued. This will be ongoing. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the required postings regarding Medicare/Medicaid application and numbers for the Ombudsman and the Indiana State Department of Health local and toll free "complaint" lines was reviewed. The staff's role to assist residents to secure this information	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155245	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/28/2011
NAME OF PROVIDER OR SUPPLIER: CASTLETON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 7630 EAST 86TH ST INDIANAPOLIS, IN		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 160	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure funds were distributed to executors of estates within 30 days, for 2 of 2 deceased residents reviewed. (Resident #117, #118) Findings include: During closed record review on 1/28/11 at 1:00 p.m., two residents who expired at the facility (Resident #117 & #118) were reviewed. The executors of their estate had not been distributed the remaining funds of these residents within 30 days of their deaths. During interview with the Business Office Manager on 1/28/11 at 1:00 p.m., she indicated Resident #117 expired on 8/1/10, with remaining funds distributed to the executor on 9/28/10. The business manager also indicated Resident #118 expired on 11/30/10, with funds distributed to executor on 1/13/11. 3.1-6(h)

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

F 160
Element #1
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
It is the policy of this facility to see that all residents who expire have any personal funds which are deposited with the facility conveyed to the individual or probate jurisdiction administering the resident's estate within 30 days along with a final accounting of those funds. As stated, Residents #117 and #118 have had this transaction completed. Going forward this will be the practice.

Element #2
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
A facility wide 60 day "look back" audit has been conducted to see if there were or are any residents who have expired and did not or have not receive(d) their funds as per requirement. Any concerns were addressed. Going forward, the bookkeeper will keep a record of all residents who expire and will track weekly with the Administrator and the corporate office to see that all funds and accounting of said funds are properly distributed to the appropriate legal party within 30 days. If for any reason this is not accomplished a full report as to 'why" will be made and ongoing effort will be documented until the conveyance is accomplished.

Element #3
What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
An all staff in-service held Feb 15, 2011, the Administrator explained this requirement of resident fund money should the resident expire. The Administrator and Bookkeeper met at a second meeting this day to discuss tracking of these types of funds. The weekly tracking of such funds by the Bookkeeper, Administrator and corporate office were reviewed. Any monies that are not returned timely after the death of a resident will be explained. Ongoing efforts will be made and documented until said monies are properly refunded.

Element #4
How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date.
At the monthly Quality Assurance meetings tracking of resident's funds and the accounting of those funds will be reviewed. Any patterns will be addressed. If necessary an action plan will be written by the Administrator and monitored weekly until resolution.
Completion: 02/27/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 7 contained the local telephone number for the Indiana State Department of Health complaint line, but did not contain the toll-free number for anyone who lived outside the local area. On 1/27/11 at 6:45 p.m., the Administrator and Consultant indicated the required information was posted in the employee break room. Both indicated the residents were able to go in the break room. On 1/28/11 at 7:21 a.m., the sign on the door to the employee break room indicated, "Employees Only." Upon entrance to the room, there was no Medicare/Medicaid information posted in the room. On 1/28/11 at 11:00 a.m., the Quality Assurance Consultant indicated there used to be some brochures available in the foyer which described Medicare/Medicaid services, however, he was unable to locate them when he went to look for them. B. Interview with the Business Office Manager on 1/28/11 at 10:35 a.m. indicated Notice of Medicare Non-Coverage was the responsibility of the Social Service Department. Interview with SS #1 on 1/28/11 at 1 p.m. indicated she was aware of the need to provide residents with notice and a form when the resident was going to be discharged from skilled services. SS #1 provided Notice of Medicare Non-Coverage for four residents discharged in the past year. 1. A 1/28/11, 4:00 p.m. review of the form entitled OMB (Office of Management & Budget) Approval No. 0938-0910 for Resident #14 indicated she was informed current Medicare services would end on 2/26/10 due to "no longer receiving skilled therapies." There was no signature indicating the	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 8 resident's representative was informed of the non-coverage, except for a facility written name and date indicating the representative was informed by telephone on 2/24/10. The facility failed to include specific reasons the benefits were ending and failed to include if the resident's representative received the notification. 2. A 1/28/11, 4:00 p.m. review of the OMB Approval No. 0938-9010 for Resident #59 indicated the resident was informed on 12/17/10 of a 12/16/10 end to Medicare services. The reason for the termination of services was "Discharge - end of PT/OT (Physical Therapy/Occupational Therapy) Services." The resident signed the form on 12/17/10. The facility failed to notify the resident two days prior to the discharge and failed to give specific reasons the benefits were ending. 3. A 1/28/11, 4:00 p.m. review of the OMB Approval No. 0938-9010 for Resident #82 indicated the resident was informed on 12/17/10 of a 12/16/10 end to Medicare services. The reason for the termination of services was "Discharge - end of PT/OT services." The resident signed the form on 12/17/10. The facility failed to notify the resident two days prior to the discharge and failed to give specific reasons the benefits were ending. 4. A 1/28/11, 4:00 p.m. review of the OMB Approval No. 0938-9010 for Resident #80 indicated the resident was informed on 12/17/10 of a 12/17/10 end to Medicare services. The reason for the termination of services was "Met	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 9 requirements." The resident signed the form on 12/17/10. The facility failed to notify the resident two days prior to the discharge and failed to give specific reasons the benefits were ending. 3.1-4(j)(3)(A) 3.1-4(j)(3)(C)	F 156	**F 157** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all changes of condition are immediately shared with resident, resident's physician, resident's legal guardian and/or an interested family member. Resident #64 currently has healing of skin where his brace rubbed a blister on his leg. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding however the facility's policy is to inform the necessary parties upon discovery of an open skin area. This was isolated incident of failing to immediately report. All residents receive weekly skin assessments head to toe by licensed nurses. In addition, C.NA's observe resident's skin during care. If any assessment by a nurse reveals an open area, this is immediately properly reported. If a C.NA observes an open area they	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 10 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the physician was promptly notified of a change in a resident's skin condition which resulted in a pressure sore cause by an immobilizer. This affected 1 of 18 residents whose clinical records were reviewed in the Stage 2 sample of 44. (Resident #64) Findings include: The clinical record of Resident #64 was reviewed on 1/25/11 at 10:59 a.m.. Nurses notes indicated the following: 1/25/11 (no time indicated) "Writer on weekly skin assess. . .one area on (R) (right) inner leg caused by leg brace, abrasion, one skin tear. . .Monitor and report that (R) knee to (illegible words). . .concerned use of leg brace, can it be D/C (discontinued)? causing more harm than good? Wound care team to look at. . ." The next entry in nurses notes was dated 1/27/11 at 4:30 p.m. and indicated the wound care team was here to see the patient. On 1/27/11 at 3:00 p.m., the wound care specialist and Assistant Director of Nursing (ADON) were observed checking the wound. Upon entry to the room, the right leg was uncovered and the resident was observed with his right leg drawn up and the immobilizer in	F 157	notify a nurse who does the assessment and this is then reported to all appropriate parties. This policy practice is ongoing. The D.O.N. or designee will monitor the 24 hour sheets daily for new open areas to see that proper reporting take place. Also, the D.O.N. or designee will check the weekly skin assessments upon completion to see that all proper reporting is done. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the requirement for reporting any change of condition including any open skin area immediately upon discovery to the appropriate parties was discussed. The nursing staff's role in reporting and assessing (which is done by a licensed nurse) was discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 11 place, pressing into the back of the leg, causing an indentation on the leg. The wound care specialist took off the immobilizer and said it should only be on when the resident was out of bed; it has rubbed blisters. An area was noted on the back of the leg, 1.0 X 4, X 0.1 cm area, with yellow slough tissue, at the center of the wound. The wound care specialist indicated to discontinue the brace. Documentation was lacking the physician had been promptly notified of the area caused by the brace when it was discovered on 1/25/11. The brace was discontinued on 1/27/11 and a treatment order obtained for the pressure area resulting from the immobilizer. 3.1-5(a)(2) 3.1-40(a)(3)	F 157	***quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the results of the 24 Hour Report Sheet monitoring and weekly skin assessment sheet monitoring will be reviewed. Any concerns will have been addressed upon discovery. Any patterns will be identified. If necessary an action plan will be written by the Administrator. The Administrator will monitor weekly until resolution. **Completion Date: 02/27/11**	
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or	F 159	**F 159** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all resident funds are managed according to regulation. Residents #3 and #83 currently have access to their funds in evening hours and on weekends. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 12 petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure availability of funds to residents in the evening hours and on weekends for 2 of 7 residents interviewed regarding personal fund availability. This had the potential to affect 24 residents who had their personal funds managed by the facility. (Residents #3, #83) Findings include:	F 159	***will be taken;*** All residents who have funds and who might desire these funds in the evening or on weekends could be affected by this finding. Currently, residents will be able to obtain their available funds until 7pm. on weekdays and from 8am until 5pm on Saturdays and Sunday. The receptionist or the nurse supervisor will be the person who will handle and record this transaction. The bookkeeper or administrator will reconcile these transactions on the following day or on the next business day. These funds will be kept in a locked secure area. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the availability of residents to access their funds and who will conduct the transaction will be reviewed. The staff will assist residents as necessary to get to the receptionist or nurse supervisor for after hours transactions. Further, the Resident Council will be informed of their ability to retrieve funds and how to do this after hours. Any staff who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 13 During an interview with two residents on 1/25/11 (Resident #3, #83), both indicated, "you have to get your money on Friday before staff leave," and it is not available in the evenings or on weekends. A review of the admission packet, provided by the business office manager on 1/29/11, indicated "money in personal funds account is available during business hours Monday through Friday." During an interview with the business office manager on 1/29/11 at 4:00 p.m., she indicated there has not been any facility communication to any of the residents to inform them of availability of money during the evenings or on the weekends.	F 159	fail to comply with their role as stated in the in-service will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the after hours banking program will be reviewed. Any concerns will be discussed. The Administrator and Bookkeeper will address any questions or concerns and resolve them as they present. Completion Date: 02/27/11	
F 164 SS=D	3.1-6(f)(1) 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	**F 164** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that each resident has their personal clinical records regarded with personal privacy and confidentiality. Residents #91, #83 and #1 all have access to private areas in which to visit with friends or family. For years the facility has made available	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 14 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a private space for residents to meet with visitors. This affected 3 of 16 residents interviewed regarding privacy in the Stage 2 sample of 44. (Resident #91, #83, and #1) Findings include: 1. During interview of Resident #91 on 1/25/11 at 10:37 a.m., she indicated there was not a private area in which she could meet with her visitors. She resided in a room with a roommate and indicated when visitors come, they stay in her room. The resident's clinical record was reviewed on 1/26/11 and an activity assessment, dated 9/17/10, indicated the resident was alert and oriented to person, place, and time. 2. During an interview on 1/25/11 at 2:24 p.m., Resident #83 indicated there is no private place in the facility to visit with visitors. She indicated most of her visitors are family and they have to visit in her room. This resident appropriately	F 164	a room with a table and chairs and a telephone for private visits. Many residents have used this room for private birthday parties and so on. Further, there is a larger lounge area room across from the receptionist desk which can be used for private visits. The facility will remind the residents of this availability. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who desire a private area in which to visit and who are not aware of availability could be affected by this finding. At Resident Council meetings the availability of private visiting areas will be shared. Further, the availability will be posted with Resident Rights. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the available private space visiting areas was reviewed. Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 15 answered screening questions prior to the interview on 1/25/11. During a second interview on 1/28/11 at 9:30 a.m. resident indicated she does not have a private place to meet with visitors. Resident indicated she had a family member visit yesterday and they had to meet in the dining room with all the other residents in there. She indicated there is no place other than her room to visit privately. 3. During an interview with Resident #1 on 1/24/11 at 4:02 p.m., the resident indicated she does not have anyone to be private with, and does not have any visitors other than her sister. This resident appropriately answered screening questions prior to the interview on 1/24/11. During a second interview with the resident at 9:00 a.m. on 1/27/11, the resident indicated, "If I did have a visitor, I would like a room all to myself." When asked, the resident indicated she has not talked to the staff about this issue. 4. During interview of the Social Service staff #1 on 1/27/11 at 3:15 p.m., she indicated they were currently working to rearrange some office space in order to accommodate residents who would like a private area for visitation. 3.1-3(p)(5)	F 164	will be reminded to direct residents to these private areas should they desire to do so. Any staff who fail to comply with the points of the in-services will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the Resident Council meetings will be reviewed. Any concerns of a private meeting room will be addressed although as these desires for a private meeting area occur, staff will direct the resident and visitor to a private area. Should a problem be identified the Administrator will personally address and resolve it. **Completion Date: 02/27/11**	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced	F 166	**F 166** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 16 by: Based on record review and interview, the facility failed to ensure a resident received a prompt resolution to a grievance, in that the resident had a grievance from September 2010 without resolution. This affected 1 of 1 resident who voiced a concern of an unresolved grievance in the Stage 2 sample of 44. (Resident #114) Findings include: Resident #114 indicated during interview on 1/26/11 at 10:30 a.m. she had an issue that didn't get resolved. She indicated she had a brand new pair of jeans in September, which she received as a gift, and they turned up missing. She indicated she had been discussing the missing jeans with the Social Service Director (SSD). She indicated the SSD said the facility should replace items if they are listed on your personal item list and it comes up missing. She indicated she felt the facility had been giving her the run around. Resident #114 indicated she talked with the SSD last on 1/24/11 and she was told they would replace them. She indicated there was also a towel blanket that had been damaged/bleached in the laundry that was supposed to be replaced, but it had not been done yet either. On 1/27/11 at 10:00 a.m., Resident #114's clinical record was reviewed. According to nurses notes of 1/26/11 at 9:40 p.m., the resident was alert and oriented x 3. Social Service notes included a Mini-Mental assessment, dated 7/13/10, which indicated a score of 25 with 25-30 indicating normal functioning. Social Service notes did not include any information regarding missing/damaged items and/or resolution.	F 166	that grievances of residents are resolved promptly and to the satisfaction of the resident. Resident #114 has had the jeans and towel replaced although there is nothing to indicate the resident ever had these jeans as her daughter doesn't recall them and they did not appear on the residents inventory sheet. No staff recall the jeans (black with flowers) either. Going forward all grievances will be addressed and resolved in a prompt and timely manner with the appropriate forms signed and dated by the appropriate staff. The resident will be informed of the resolution timely. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who have a grievance have the potential to be affected by this finding. Going forward all grievances will be dated and will be addressed in a timely fashion from submission t resolution. The Social Service Director will spearhead the resolution process in cooperation with any other appropriate staff and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 17 During interview of the Social Service Director on 1/27/11 at 3:45 p.m., she indicated the grievance procedure was as follows: Have a concern form she documents on, without fear of repercussion; this goes to administrator and any involved supervisor also gets copy; there is follow-up with person after they have addressed concern. She indicated missing property ends up on a concern form and goes to nursing and housekeeping and they do a search for items and she contacts family to find out any information she can from family, description, anything that might help find the item. The SSD indicated the policy for replacing items is up to administrator depending on what it is and how much; usually replace it, but up to administrator - usually do replace; "pretty good about that." Regarding Resident #114's missing jeans, the SSD indicated she has followed up weekly with Administrator since she started working here (around Thanksgiving). She indicated they thought the jeans had been purchased by the previous social service staff member before she left, and they had tried to call her to see if she did purchase them, and then she wrote up the concern form and has been awaiting a decision (from the Administrator). She indicated she heard about it the week after the previous social service staff member left, has been almost a month, has offered to buy jeans and a towel, and has been waiting to find out. The SSD indicated on Monday, 1/24/11, Resident #114 came into the hallway and found her and asked her about the jeans, wondering about why there was a delay. The SSD took her to the Administrator's office and asked him, and he said he was working on it.	F 166	the Administrator. Most grievances should be able to be resolved within 48 to 72 hours. Those taking longer will have weekly progress notes and updates to the party who made the grievance. These will be documented. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the grievance process was reviewed. The Social Service Director's role was explained. Further, the Administrator and the SSD will review all grievances and progress to their resolution at least twice weekly. Staff will be reminded to direct any resident or visitor who has a grievance to the Social Service Director. Any staff who fail to comply with their role in the grievance process will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 18 During the exit conference on 1/27/11 at 7:00 p.m., the administrator indicated when he first learned of the concern of the jeans, he called the resident's daughter who told him she didn't recall her mother ever having a pair of black jeans like she was describing; He indicated the facility also talked with the nurse who inventoried the resident's belongings and she did not recall any black jeans with red flowers and described other jeans the resident had. He indicated when the facility does something; i.e. damages, loses items, breaks items, they do replace the item, but it could not be determined that the resident indeed did lose the jeans. On 1/27/11 at 4:30 p.m., the Administrator provided a copy of the "Lost or Stolen Personal Property of the Residents" policy. This policy indicated a report of concern shall be completed at the time of the missing item and forwarded to the Administrator. The procedure indicated following an investigation, the facility would orally or in written form report to the resident or his/her legal representative the results of the investigation in the event the lost or stolen item is not recovered. The procedure also indicated the Administrator had the discretion to replace items if the facility is at fault related to the missing item(s). A concern form, dated 11/30/10, and signed by the administrator, without date, indicated Resident #114 had "previously reported to (name) (ex-social worker) that she was missing a pair of black denim jeans with colorful designs on the pocket and hadn't heard anything in regard to the issue." No concern form prior to 11/30/10 was provided for review. Resident #114 indicated she	F 166	At the monthly Quality Assurance meeting the grievance process will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by the Administrator. The Administrator will review the plan weekly until resolution. **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166	Continued From page 19 first reported the missing item in September 2010. There was no concern form related to the blanket towel, which was damaged and which the resident said she had reported to SSD. The "Findings/Resolution" section of the form indicated "Talked to res. (resident's) daughter who didn't recall what jeans (exactly) her mom was talking about. Daughter didn't believe res. was missing anything." The form indicated Resident #114 was informed of the "resolution" on 12/16/10. A second concern form, dated 1/21/11, indicated Resident #114 had "voice (sic) concern over missing jeans. Informed (Resident #114) would check her account to buy new jeans." The "Findings/Resolution" indicated staff checked with the business office on 1/27/11 at 4:30 p.m. and the resident did not have enough funds to purchase jeans. The section of the form, "Resident or Person Notified of Resolution/Date/Time" was blank and the "Signature/Title/Date of person Resolving Concern" was blank. The SSD and administrator both signed the form, but the signatures did not include a date. The undated policy, Complaints and Grievance, was provided for review by the Administrator on 1/27/11 at 10:00 a.m. The policy indicated the facility would ". . .make prompt efforts to resolve grievances. . ." 3.1-7(l)(2)	F 166		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and	F 170	**F 170** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that the residents have their right to privacy to send/receive unopened mail. Currently the Resident Council president does not have their mail opened prior to delivery. Any mail that appears to be a bill needing to be paid by the business office on behalf of the resident and their permission will be obtained to open the mail of for them to open the mail and examine it and they allow it to be returned to the business office for payment processing again on the resident's behalf. This practice includes all residents. NOTE: The exception would be if a resident per choice would request certain mail to be opened and handled by the facility staff as a service. This will be documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 170	Continued From page 20 promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure residents' right to privacy in that mail was not always delivered unopened. This affected 1 of 1 resident interviewed related to mail and had the potential to affect all 78 residents residing in the facility. Findings include: During interview of the resident council president on 1/26/11 at 10:30 a.m., she indicated mail is delivered to residents but her mail had been opened at times. She indicated she wasn't sure why, but it has been opened. She indicated the opened mail she had received was personal bills. She indicated it had occurred in the past year and it had occurred 1-2 times. During interview of the Activity Director on 1/27/11 at 9:30 a.m., she indicated she delivers mail to residents. She indicated she passes it out when it arrives and some things are opened. She indicated the receptionist is required to open any bills or anything that would go to the business office and that personal mail was not opened. During interview of the receptionist on 1/28/11 at 12:30 p.m., she indicated she is responsible for sorting the mail and that she opens any mail to residents that is labeled "C/O (care of) Castleton Healthcare Center" that might need to go to the business office.	F 170	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Henceforth, all mail will be delivered unopened to the residents. Any mail that appears to be a bill needing to be paid by the business office on behalf of the residents will be delivered to the residents and their permission will be obtained to open the mail or for them to open the mail and examine it an then allow it to be returned to the business office for payment processing again on the resident's behalf. The SSD or their designee will interview ten residents weekly to be sure their mail is delivered unopened. Any concerns will be addressed upon discovery. This monitoring will continue until four consecutive weeks of zero negative findings is realized. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;***	

F 170 continued:
15, 2011, the Resident's Right regarding mail being delivered/sent unopened was reviewed. Any staff who fail to comply with their role in promoting this resident right will be further educated and/or progressively disciplined as needed.

Element #4

How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date

At the monthly Quality Assurance meeting the monitoring of the mail Deliveries will be reviewed. Any concerns will have been resolved upon discovery. The Administrator will be notified immediately of any opened mail and will research and address it.

Completion Date: 02/27/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 170	Continued From page 21 3.1-3(s)(1)	F 170		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F 225** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all allegations of abuse are thoroughly investigated and reported to the state agency. Any concerns of rough treatment by Resident#42 or any other resident will be investigated and reported to the state agency. Resident #80 has been reminded to report any treatment she considers "rough" to the charge nurse immediately so investigation and reporting can take **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. All reports of "rough" treatment or any other abuse or potential for abuse-type treatment to a resident will be thoroughly investigated and reported to the state agency. This includes abuse of alleged abuse. allegations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 unusual incidents reviewed were thoroughly investigated and reported to the state agency for 2 of 3 residents alleging abuse in the Stage 2 sample of 44. (Resident #42 & 80) Findings include: 1. Resident #42 was interviewed about her care on 1/24/11 at 3:15 p.m. She indicated staff had been "rough" with her. She also indicated she had not reported this concern because the staff "don't mean to, they just get in a hurry." The Administrator was interviewed on 1/26/11 to determine if Resident #42 had reported any concerns. He indicated she had not. The Administrator provided the investigation of a concern presented by Resident #42 during October 2010. The Concern Form was provided on 1/27/11 at 1:30 p.m. Review of the Concern Form, dated 10/29/10, indicated the resident had reported a concern about being handled roughly by a CNA on the 10p-6a shift. The facility investigated by interviewing four other alert and oriented residents and they said the CNA "was very nice." The resident was interviewed on 10/30/10 for any further details or concerns and was unable to recall having expressed the original concern. The Administrator indicated on 1/27/11 at 1:30 p.m., there was nothing further done with the report. He indicated there was nothing else to do with the	F 225	Going forward, the Administrator and DON or designee in nursing administration will spearhead all abuse or allegations of abuse investigations. These will be reported to the state agency and all other appropriate parties as indicated which may include the Ombudsman, Adult Protection Services, physician, family, registry or licensing agencies and possibly the police. Incidents of abuse or alleged abuse require immediate initiation of the investigation/reporting process by Administration. The Administration is to be informed immediately. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff in-service held Feb 15, 2011, the necessity to immediately report all incidents of abuse or alleged abuse immediately to the charge nurse was reviewed. The charge nurse will notify the DON/Administrator and an investigation will begin immediately. Reporting to all appropriate agencies/parties will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 23 report. 2. Resident #80 was interviewed on 1/25/11 at 8:45 a.m. about the care she received in the facility. She indicated she was afraid, but not for herself in the facility, but for her roommate. She indicated the staff were "always in a hurry" and became "very impatient" with her roommate. She indicated her roommate had "gone downhill very quickly" and was not able to make her needs known. During an interview with Resident #80, on 1/28/11 at 8:20 a.m., the resident indicated she had reported the allegations and the facility investigated them. She no longer had concerns with the staff for treatment. She indicated the incidents had occurred about two months ago. She indicated the concerns had been resolved and were more "personality clashes." The Administrator was interviewed on 1/27/11 at 11:30 a.m. He indicated there had been no allegations of abuse from Resident # 80 reported to him. He also indicated he had no concern forms or grievance forms to submit for review for Resident # 80. 3. The Abuse Prevention and Response Policy, presented by the Administrator on 1/26/11 at 3:50 p.m., indicated the following: "....V. ....3. All events reported, as possible abuse will be investigated to determine whether abuse did or did not take place... VII. Reporting and Response Issues:....2. Any investigation that substantiates abuse or neglect finding will be reported immediately to the Administrator or his/her designated representative and to other officials in accordance with State Law within 5 working days	F 225	done. Within twenty-four hours the state agency needs to be notified with a five day follow-up report to follow. Any staff who fail to comply with their role in reporting/investigating abuse will be disciplined up to and including termination. NOTE: The Resident Council agenda will include an agenda topic on "abuse" (along with Resident Rights) and how to report abuse or alleged abuse. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings all incidents of abuse or alleged abuse will be reviewed. Any patterns will be identified. If necessary, and action plan will be written by the Administrator and monitored weekly until resolution. The facility has zero tolerance policy for abuse. **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 24 of the event...." 3.1-28(c) 3.1-28(d) 3.1-28(e)	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement policies to investigate any allegations of abuse and report them to the state agency as required by law. This affected 2 of 3 residents interviewed who indicated they had been handled roughly by staff in the Stage 2 sample of 44. (Residents #42 & #80) Findings include: 1. The Abuse Prevention and Response Policy, presented by the Administrator on 1/26/11 at 3:50 p.m., indicated the following: "....V. ....3. All events reported, as possible abuse will be investigated to determine whether abuse did or did not take place... VII. Reporting and Response Issues:....2. Any investigation that substantiates abuse or neglect finding will be reported immediately to the Administrator or his/her designated representative and to other officials in accordance with State Law within 5 working days of the event...."	F 226	**F 226** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all allegations of abuse are thoroughly investigated and reported to the state agency. (See Response to Element #1 F225) **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** (See Response "To Element #2 F225) **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** (See Response to Element #3 F225)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 25 2. Resident #42 was interviewed about her care on 1/24/11 at 3:15 p.m. She indicated staff had been "rough" with her. She also indicated she had not reported this concern because the staff "don't mean to, they just get in a hurry." The Administrator was interviewed on 1/26/11 to determine if Resident #42 had reported any concerns. He indicated she had not. The Administrator provided the investigation of a concern presented by Resident # 42 during October 2010. The Concern Form was provided on 1/27/11 at 1:30 p.m. Review of the Concern Form, dated 10/29/10, indicated the resident had reported a concern about being handled roughly by a CNA on the 10p-6a shift. The facility investigated by interviewing four other alert and oriented residents and they said the CNA "was very nice." The resident was interviewed on 10/30/10 for any further details or concerns and was unable to recall having expressed the original concern. The Administrator indicated on 1/27/11 at 1:30 p.m., there was nothing further done with the report. He indicated there was nothing else to do with the report. 3. Resident #80 was interviewed on 1/25/11 at 8:45 a.m. about the care she received in the facility. She Indicated she was afraid, but not for herself in the facility, but for her roommate. She indicated the staff were "always in a hurry" and became "very impatient" with her roommate. She indicated her roommate had "gone downhill very quickly" and was not able to make her needs known.	F 226	**Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** (See Response to Element #4 F225) **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 26 During an interview with Resident #80, on 1/28/11 at 8:20 a.m., the resident indicated she had reported the allegations and the facility investigated them. She no longer had concerns with the staff for treatment. She indicated the incidents had occurred about two months ago. She indicated the concerns had been resolved and were more "personality clashes." The Administrator was interviewed on 1/27/11 at 11:30 a.m. He indicated there had been no allegations of abuse from Resident #80 reported to him. He also indicated he had no concern forms or grievance forms to submit for review for Resident #80. 3.1-28(c) 3.1-28(d) 3.1-28(e)	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide individual attention and cueing to ensure a dignified dining experience for 11 identified residents and 7 additional unidentified residents observed, during 2 of 2 lunch meals in 2 of 4 dining areas. (Residents #87, #37, #14, #5, #68, #41, #21, #28, #64, #17, #73) Findings include:	F 241	**F 241** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that care is provided to the residents in an environment that maintains the resident's dignity and respect. Currently food delivered on trays is not left on the tray unless a resident specifically request this and it is care planned. Resident #41 receives all necessary interventions to eat	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 27 1. During observation of the Special Care Unit on 1/24/11 at 12:05 p.m., lunch was served on trays and left on trays in front of the residents. LPN #2 sat by Resident #41 and encouraged and assisted him to eat. She encouraged other residents to eat from her location at Resident #41's side. This required her to yell across the room to the other residents. During this time, Resident #87 had started to eat but then placed her meat and potatoes in her dessert and no staff intervened. One resident came in and sat at the table with Resident #41. She was eating with her knife and no staff intervened. At 12:17 p.m., five trays remained unserved. LPN #1 indicated only one resident ate in their room and the remaining four residents needed reminded to come to the dining room. At 12:34 p.m., the final tray was served when Resident #37 was brought to the dining room. 2. The following was noted during lunch observation on the Special Care Unit on 1/27/11: At 12:29 p.m., a resident was taken to a physician's appointment by ambulance and had not been served lunch before leaving. LPN #2 reported she would only be gone a few minutes. Trays arrived at 12:29 p.m. Resident #37 was served and had food prepared, but did not start eating. Resident #14 , at the same table, sat in front of her food, not eating. Resident #14's meat, a piece of steak, was not cut for her. Resident #73 was served her meal by staff; staff left and came back to feed her when all the trays	F 241	their meal safely and with dignity and comfort. Staff does not call across the room to cue. Residents eat before being taken to any appointments close to mealtimes. Residents 37,24,87,73,68 and 5 receive all needed interventions to eat their meals safely and with dignity and comfort. All residents have condiments and salad dressing used unless they don't want it. All residents receive trays at the same table at the same time in order. Residents 21 and 28, 64 and 17 receives all needed interventions to eat meals safely and comfortably. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Going forward the nursing administration, charge nurse will monitor all meals going forward to see that trays are delivered timely and in order at each table. Also, to see that all proper cues are given along with encouragement to eat. Further, all condiments and dressing will be used. Staff will perform all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 28 had been passed at 12:40 p.m. During this time, the resident was trying to eat her cornbread with her hands. She was left alone and she began eating pinto beans with her hands. Resident #68 had ground meat on her tray, and also a green lettuce salad with a large chunk of cauliflower. There were magazines laying beside the resident's meal tray. The resident kept going from meal to magazine, without staff intervention/direction. At 12:46 p.m., LPN #2 sat down between Residents #37 and #87. Resident #14 continued to not eat, with no staff encouragement at 12:51 p.m. At 12:53 p.m., Resident #87 put her dinner plate in the middle of the table, after eating cornbread and a few bites of greens; no dressing was put on the salad. Resident #5 put the dinner plate off to the side of her after consuming a few bites of greens and cornbread; she put the salad on the tray, along with pinto beans, but was not eating and was not encouraged by staff to eat. There was no staff encouragement for Resident #87 to eat. She took a health shake and attempted to put a fork into the carton, picked up a straw and put it into the health shake and drank some of it. Staff encouraged her to eat her cake, but did not put the cake in front of her or assist her. One resident sat at a table by herself, had no dressing on her salad, and wasn't encouraged to	F 241	interventions to see that meals are consumed by residents with as much assistance as necessary to make the dining experience pleasant and comfortable and dignified. Any resident that eats 50% or less will be offered a substitute. The DON or designee will monitor six meals weekly (two breakfasts, two lunches, and two dinners) for completeness of service, and "salty" taste or toughness of meat. Also, touching of bread and utensils (except handles) with bare hands. All concerns will be corrected immediately as found. The monitoring will go on until four consecutive weeks of zero negative findings have been realized. Afterwards weekly monitorings will continue on all meals by nursing administration. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the dining experience was reviewed. The following was covered: a. Serve all residents at the same table together.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 29 eat. At 12:55 p.m., Resident #14, who had been served first, sat at the table and was not encouraged to eat. Resident #5 was not encouraged to eat, and moved her salad from her plate to the table. At 1:15 p.m., Resident #68 was stuffing an advertisement, from the magazines beside her, in a cup and was still not eating. Resident #37 sat next to her, was fed by the nurse, but not encouraged to eat. Resident #87 took two bites of cake and then fell asleep. At 1:16 p.m., Resident #68 was asked if she was finished; she was offered other things and refused; offered another "Boost" and refused, stating she was not very hungry. At 1:16 p.m., Resident #5 dumped beans from the bowl onto her plate, spilling them onto the table and started stacking dishes. The resident who had gone for the physician's appointment at the beginning of the meal had not returned at the conclusion of the observation period. 3. During the first dining observation of lunch on 1/25/11 at 12:00 p.m. in the main dining room, the following was observed: One resident at a table was served food; 10 minutes later the other three residents at this same table were still waiting for food.	F 241	b. Use condiments and dressings to liking. c. Give cues and encouragement. d. Do not "yell" across room. e. Intervene quickly for spills f. Cut up food/prepare food for eating as needed g. Remove food from serving tray h. Don't leave food in front of resident without helping them to eat. i. Don't let appointments interfere with meals j. Document intake, offer substitute if less than 50% of meal eaten. k. Importance of nutrition Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as needed. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meeting the results of the meal service monitoring will be reviewed. Any patterns will be identified. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 30 Resident #21 had difficulty lifting her ice water and spilled half of the ice in her drink onto the table. It was 10 minutes before staff noticed it to assist the resident. Resident #28 was in a recumbent wheelchair and unable to reach her food on the table. The resident was wheeled back to the room, without eating any food. 4. During the second dining observation of the main dining room on 1/28/11 at 12:15 p.m., the following was observed: Fifty percent of the residents sitting at the same table were served at different times, sometimes up to 10 minutes apart. Resident #21 did not receive any staff assistance to cut her meat or open her milk. The resident yelled, "nurse come help me, no one cut my meat or opened my milk." Resident #28 was in a recumbent wheelchair and did not reach the table. A staff member cut her meat while standing over her, then left the resident. The resident could not reach the items on her tray and did not feed herself. Ten minutes later, a staff member came back to her table and pushed her wheelchair up closer to the table. The resident tried to reach her food, but was still unable to reach it. Resident #64 was not assisted or fed and all of his meal was untouched. Resident #17 ate 3/4 of her cornbread and the remainder of the food was left uneaten. No staff members were observed to assist the resident.	F 241	necessary, an action plan will be written by a committee appointed by the Administrator the plan will be monitored weekly until resolution is achieved. **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 31 3.1-3(t)	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents were involved in choosing their schedules, i.e. time rising or going to bed and bath schedules, based on their own preferences. This affected 2 of 16 residents reviewed for choices in the Stage 2 sample of 44. (Resident #56 and #42) Findings include: 1. Resident #56 indicated, during interview on 1/24/11 at 3:10 p.m., that she did not have any say in when she was assisted up in the mornings. She indicated staff had so many people to get up in a certain period of time and she had to just go along with their schedule. According to the Minimum Data Set (MDS) assessment, with assessment reference date of 12/29/10, the resident's functional status was as follows: Transfer - requires assist of 1 person Walk in room & corridor - did not occur	F 242	**F 242** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that residents have the right to choose schedules whenever possible. Currently Residents 56 and 42 are receiving care as per schedule of their choice. All interviewable residents have been interviewed as to their preference as for as a time to get up and time/day to shower. Every effort is being made to accommodate their wishes. This is documented. As residents are admitted their preferences for schedules will be honored as much as possible and to the residents liking. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 32 Balance during transitions and walking - Moving from seated to standing position - not steady, only able to stabilize with human assistance Surface-to-surface transfer - transfer between bed and chair or wheelchair - not steady, only able to stabilize with human assistance Nurses notes, dated 1/25/11 at 10:00 a.m., indicated the resident was alert and oriented to person, place, and time. 2. On 1/27/11 at 6:37 a.m. on the Skilled Unit, eight residents were observed up and sitting in dining area. Additional residents were up in the wheelchairs in their rooms. RN #1 had to wake a resident for an accucheck (blood sugar test), stating she's sleepy this morning. She had to continue to nudge the resident during the test to keep her awake, and the resident returned to sleeping in her wheelchair after the accucheck. 3. Resident #42 was interviewed about her choice of care on 1/24/11 at 3:15 p.m. She indicated she did not get to choose when she was awakened in the morning. She indicated she got up at 5:30 a.m. and that was "too early." She also indicated she couldn't use the shower until she was "told to." She also indicated this was not acceptable to her. The resident's clinical record was reviewed on 1/24/11 at 3:15 p.m. The Minimum Data Set assessment, dated 11/17/10, indicated the resident required assistance of one staff person for toileting, hygiene, mobility, and transferring. The care plan, dated 11/11/10, indicated the resident had a deficit in her ability to perform her own activities of daily living. The care plan indicated "allow rest periods; anticipate and meet	F 242	All residents who are able to make decisions have the potential to be affected by this finding. Going forward, the Social Services Director will interview 10 interviewable residents weekly to see that their wake up times and shower days/time are to their liking. Any negative responses will be addressed immediately. This monitoring will continue until four consecutive weeks of zero negative findings are realized. Afterwards, random weekly monitorings will occur. C.NA assignment sheets will reflect preferences. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the importance of honoring resident preferences as far as time/schedules such as wake up time and shower day/time were reviewed. Any staff who fails to comply with meeting this resident right will be further educated and/or progressively disciplined as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 33 all needs; appointment with podiatrist; ask family to bring in favored articles; ask her what she wants to wear for the day; assist in choosing appropriate clothes for season; assist with bed mobility q2h; assist with gait belt transfers; assist resident with all aspects of the adl process; assist to toilet as needed; encourage to toilet upon rising, ac, pc, hs, on request, prn and every 2-3 hrs, cue to wash face; dentures cleaned and in place daily; set up oral care supplies assist as needed; set up meals, assist with meals as needed encourage hair removal from chin; explain all aspects of care as needed; shampoo hair twice weekly; shower 2 times weekly, partial baths 5 other days." The CNA Assignment Sheet, dated as updated on 1/20/11, indicated the bath days for Resident #42 were Wednesday and Saturday on the day shift. Interview with the Assistant Director of Nursing, on 1/27/11 at 2:00 p.m., indicated the resident had not expressed any concerns with her rising time or bathing times since her transfer from the rehabilitation side of the facility. She also indicated if residents did not ask for their times to be changed, the bath day was assigned to the room and bed number to even the staff assignments. 3.1-3(u)(1)	F 242	**Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitorings by the SSD for time preferences will be reviewed. Any concerns will have been addressed upon discovery. **Completion Date: 02/27/11** **F 244** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that concerns of the Resident Council concerns as expressed in their meetings are acted upon. Currently, the Resident Council meeting minutes are recorded by following an agenda which is specific and includes a topic section of concerns. The concerns are written with specifics including resident's name, date, concerns (in detail). A copy of these concerns will be given to the Administrator after the meting. The Administrator	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 34 operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure prompt resolution to grievances/concerns made by the resident council. This was noted in review of the past 11 months of resident council minutes and had the potential to affect those residents who regularly attended resident council meetings. Findings include: 1. The resident council minutes were reviewed on 1/27/11. Each monthly resident council report included a section for "Concern from last meeting" and "resolution." The documentation included, but was not limited to, the following: February 17, 2010 Concern: "1. Concerned about roommates laundry - resolved" "2. Base board behind door needs to be fixed - not resolved" "3. More activities on skilled - resolved" "4. Room not being cleaned/dusted enough - res (resident) in hosp (hospital) unable to follow up" "5. Food too salty - not resolved" March 24, 2010 Concern "4. Base board still not fixed behind door - not resolved - will fill out res concern form" April 21, 2010	F 244	will distribute concerns to appropriate party. Concerns need to be responded to as soon as possible. In order to allow some research or planning, concerns may take 48 to 72 hours to respond to the resident with a resolution or a plan which will produce resolution. As resolved, the copies will be returned to the Activity Director who will attach it to the original concern. At the next Resident Council meeting the concerns from the prior meeting(s) will be discussed including resolution. The Administrator will see that all concerns are acted upon and this will be timely. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** Any resident who has a concern could be affected by this finding. The Activity Director has been educated by a consulting Activity Director on how to improve on the Resident Council meeting minutes and the "concern" section. Going forward the Administrator will meet with the Activity Director after the meeting and weekly to check	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 35 "2. Call light not always working - not resolved" "5. Shower stall needs to be fixed - not resolved" "7. Not invited to groups - not resolved" "16. Meat too tough, food not always hot - not resolved" May 26, 2010 "10. Black pants turned brown - not resolved" June 16, 2010 "7. Staff avoids call lights - not resolved" "9. Sink lose from wall - fixed but caulking is cracking - not resolved" "10. Ants in rooms - not resolved" "11. CNAs not helping with set up with meal trays, etc. - not resolved" "12. CNAs only make bed then disappear - not resolved still continues" July 21, 2010 "6. Missing shirt, socks, panties, & stretching out clothes - not resolved" "7. Husband missing blue cashmere sweater - not resolved" "9. Call lights not being answered - not resolved" August 18, 2010 "4. Missing socks - not resolved, but residents are working at sorting socks during activity groups to help resolve" September 22, 2010 "2. Caulk around her sink is cracked - not resolved" "3. Bar in bathroom is broken - not resolved" "7. Would like to work with restorative - was but not anymore" "8. Would like to walk daily - not resolved"	F 244	progress of resolving concerns making certain all are acted upon and to the resident's satisfaction. This will be ongoing. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the importance of getting residents to the Resident Council meeting and encouraging them to discuss their concerns was reiterated. Helping resolve concerns of residents as to what their role calls for or allows was also discussed. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as needed. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meeting the resolution of Resident Council meeting concerns will be reviewed for timeliness and completeness. The Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 36 October 27, 2010 Portion of concerns from last meeting and resolution left blank. Areas of concern noted on various departments, including, but not limited to, laundry won't bring clothes, CNAs don't flush the toilet after emptying bedpan, medications still being administered late mostly on the weekends, CNAs not answering her call light when she needs assistance. November 30, 2010 Section of "Concern from last meeting" indicated, "No concerns" Department areas of concerns included, but not limited to the following: Staff is overworked and patients being neglected, nurses need to pay more attention to residents, weekends still late with medication pass, eye glasses not returned - spoke with SS on Monday; haven't heard back. There were no concern forms with the October or November 2010 minutes. December 17, 2010 Section of "Concern from last meeting indicated, "No concerns except for department areas. (Resident name) still having a problem getting showers. Needs to be assigned. Department areas of concerns included, but not limited to the following: Wants CNAs to sanitize hands more often and not touch rolls and bread; Jeans haven't been replaced since (name of Social Service Director) left; bath blanket needs to be replaced; not getting things back from laundry. The Activity Director was interviewed on 1/27/11	F 244	will have been meeting weekly with the Activity Director to see that this happens. Any concerns will be addressed as discovered in these weekly meetings. **Completion Date: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 37 at 9:30 a.m. She indicated she is the staff member who assists with resident council meetings and takes the minutes. The indicated she writes down any grievance/concern on the grievance sheet, including the facts, who has the concern and what it is about and then takes that to the department that it applies to. She indicates she gives it to the department manager and they have 1 week to get back to her. The Activity Director indicated staff usually get it corrected immediately. She further indicated she goes back to the resident individually and asks if anyone has come and talked to them about their concern and is it resolved. She indicated they begin the next resident council meeting with concerns from the last meeting to give them a chance to talk about how it worked out. A "Concern Form" was attached to the December 17, 2010 resident council minutes. It addressed a concern of 1 resident's finances. There were no other concern forms provided for review.	F 244		
F 247 SS=D	3.1-3(l) 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 resident with a room change in a sample of 16 residents interviewed in the Stage 2 sample of 44, was notified of the planned room change prior to the action.	F 247	**F 247** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that the resident receives noticed prior to a change in room or roommate. As stated in the survey the Social Service Director is a new employee and was not aware of all that is required for a room change. Resident 83 nor any other resident will receive a room change without proper notification going forward. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who have a room change could be affected by this finding. At the department head morning meetings all possible room changes will be discussed. The Administration will discuss these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 38 (Resident #83) The finding includes: Interview with Resident #83 on 1/25/11 at 2:25 p.m. indicated there had been a room change in the past nine months and the resident had not been notified of the room change prior to it happening. Record review on 1/27/11 at 11:15 a.m. indicated the resident was admitted to the facility on 12/8/01 and readmitted on 11/5/10. There was no documentation in the Social Service notes or Nurses Notes regarding a room change. The only way to determine there was a room change was to follow the heading on the Nurses Notes which noted the resident went from Room 111 to 106 at the end of November 2010. Interview with the ADON at the time, indicated she would have social service staff review the record for room change notification. Interview with SS (Social Service Staff) #1 and #2 on 1/27/11, 3:40 p.m. indicated the resident was moved to a new room on 11/24/10. SS #2 stated SS#1 was new to the facility and did not know she was to notify the resident or family of the planned room change, but had been informed that day of the policy. SS #1 agreed she did not know of the policy of room change notification until 1/27/11. A Communication of Room Transfer form was provided on 1/27/11 for Resident #83's 11/24/10 room transfer and it was dated 1/27/11. The facility policy provided 1/27/11 at 4:30 p.m. indicated, "When a transfer or discharge of a	F 247	changes with the Social Services Director who will be certain all proper notifications take place. These changes will be properly documented. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held Feb 15, 2011, the necessity of a resident being notified of a room change as a resident right will be discussed. The policy for room changes and acceptance/agreement by the resident was reviewed. Including showing the resident the new room and introducing them to the roommate. Further a 72 hour visit will be made to ensure the resident is agreeable new room. Staff will be expected to perform their role in seeing this happens. Staff who fail to comply with points of the in-service will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 39 resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility." "If an intractability transfer is required, the resident must be given at least two (2) days before relocation..." 3.1-3(v)(2)	F 247	At the monthly Quality Assurance meetings the room changes will be reviewed. Any concerns will be addressed. The SSD and Administrator will be meting on each room change as they occur to see that all are done correctly.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure 1 of 11 residents reviewed for activities in the Stage 2 sample of 44 had an activities plan in place to meet their individual needs. (Resident #3) Findings include: On 1/26/11 at 10:00 a.m., Resident #3 was observed sleeping in her bed in her room. The activities calendar indicated Stretch exercises were occurring in the activity room, and table games were in the main dining room. At 10:30 a.m. bowling was held in the Assisted Dining Room. Resident # 3 did not attend any of the activities. Resident #3 was interviewed on 1/24/11 at 2:30 p.m. She indicated she had trouble watching television programs because of the pain in her left	F 248	**COMPLETION DATE: 02/27/11** **F 248** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that all residents have an activities program that meets their individual needs. Currently Resident #3 participates in activities of her liking. Her activity assessment has been reviewed and updated as well as her care plan. Her activity wishes and participation are documented. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who have had a change in status which might mean they aren't able to attend activities as per their plan could be affected by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 40 eye from an infection. The record for Resident #3 was reviewed on 1/26/11 at 10:40 a.m. The resident had diagnoses which included, but were not limited to schizophrenia and shingles of the face and left eye. The Minimum Data Set assessment, dated 10/29/10, indicated the resident was independent in mobility, transfers, eating, hygiene, and toileting. She was not assessed for pain because she didn't have any pain. The BIMS (Basic Information Memory Scale) assessment indicated the resident had normal cognitive status. The care plan, dated 1/27/11, was reviewed and indicated the following interventions for activities interests: "resident usually politely declines group activity - does enjoy bingo and attend live entertainment - will agree to stop by or peek in on 3 group activities - provide calendar; invite, encourage, and assist to & from; offer to go with resident just to take a look; provide 1:1 recreational activities per resident's interests if she declines numerous group activities; respect resident rights; and praise all efforts." The activity progress notes, dated 1/5/11, as part of the annual assessment, indicated the resident attended bingo, puzzle time, live entertainment, and resident council. Hobbies of interest included cooking and shopping which she was not able to do. She loved to watch talk shows and comedy. There was no need for current referrals, and documentation indicated to proceed with the plan of care as written. Interview with Activity Director, on 1/28/11 at 8:45	F 248	findings. An audit was done to see if any residents currently are not able to attend or participate in their planned activities for whatever reason. If there are residents in this situation their activity plan was addressed to provide activities to meet their current needs. Going forward the Activity Director will be notified by nursing administration (DON or designee) of any residents who have had changes that might affect their activity plan. The DON or designee will meet at least twice weekly with the Activity Director to discuss these possible needs for activity plan changes. This will be documented and ongoing. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff in-service held Feb 15, 2011, the fact that residents need activities planned for them to meet their needs was discussed. A resident might need one on one activities for a period of time if for whatever reason they are not able to participate in their usual activity plan. Staff are expected to carry out	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 41 am, indicated Resident #3 did not attend activities, but is invited. She indicated the resident should be getting 1:1 activities done by the activity assistant. The activity participation book for January 2011 was reviewed for Resident # 3. The book had no participation indicated for Resident # 3 during the month of January. There was a note in the upper right hand corner of the page. The note indicated "Ms. (Resident's name) has been extremely ill, and has had little to no participation in activities." Activity Aide #6 was identified as responsible for doing 1:1 activities. She indicated she stopped by and visited with Resident # 3 to offer snacks and drinks. She had not documented any of the visits. She also indicated she had not addressed interests of bingo, reading, or any other interventions included in the care plan. 3.1-33(a) 3.1-33(b)(8)	F 248	their role in seeing this happens. Any staff who fail to comply with the points of this in-service will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the twice weekly meetings of the Activity Director and nursing administration (DON/designee) to be certain activity plans are modified if needed. The Administrator will address any concerns as revealed. **Completion Date: 02/27/11**	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure social service staff were involved in notification and adjustment to a room change for 1 of 16	F 250	**F 250** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that medically relate d social services are provided to attain the highest practicable physical, mental, and psychosocial well-being of each resident. As stated previously, Resident #83 nor any other resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 42 residents reviewed for room change (Resident #83), and failed to ensure involvement in the review and care planning for the use of psychoactive drugs for 1 of 9 residents reviewed for psychoactive drugs (Resident #5). The facility also failed to ensure social service intervention/planning related to potential discharge and subsequent planning following a change in discharge plans (Resident #91). This affected 3 of 18 residents whose clinical records were reviewed in the Stage 2 sample of 44. Findings include: 1. During interview with Resident #83 on 1/25/11 at 9:13 a.m., she indicated there had been a room change in the past nine months and the resident had not been notified of the room change prior to it happening. Record review on 1/27/11 at 11:15 a.m. indicated the resident was admitted to the facility on 12/8/01 and readmitted on 11/5/10. There was no documentation in the Social Service notes or Nurses Notes regarding a room change. The only way to determine there was a room change was to follow the heading on the Nurses Notes which noted the resident went from Room 111 to 106 at the end of November 2010. Interview with the ADON at the time, indicated she would have social service staff review the record for room change notification. Interview with SS (Social Service) #1 and #2 on 1/27/11, 3:40 p.m. indicated the resident was moved to a new room on 11/24/10. SS #2 stated SS#1 was new to the facility and had not known she was to notify the resident or family of the planned room change, but had been informed	F 250	will have a room change without all proper notifications and paperwork completed. Resident #5 has been reassessed and has had their record reviewed including care plan, Behavior Monitoring sheets and a medication review. This review was done by nursing administration, Social Services Director, Activity Director, Dietary Director, Pharmacy Consultant and physician. Resident #5's care is given with the least amount of psychoactive meds as possible given only after attempted non-medicine interventions which are documented. Also dose reductions should be attempted unless contraindicated. Resident #91 has had her plan of care reviewed and updated. A discussion has taken place with the resident as to why she needed to stay where she could have around the clock assistance. The facility's mental health provider has been contacted to see the resident and evaluate her and her feelings on not going home. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 43 that day of the policy. SS #1 agreed she did not know of the policy of room change notification until 1/27/11. 2. During observation on 1/26/11 at 8:35 a.m., Resident #5 sat quietly feeding herself breakfast. Interview with the resident on 1/25/11 at 9:13 a.m., indicated she could state her name, was aware of her surroundings and answered questions appropriately. The 8/20/10 and 10/11/10 Minimum Data Set [MDS] assessments indicated the resident received Klonopin and Xanax for depression, anxiety, increased confusion and wanting to leave the facility. The November 2010 Medication Administration Record [MAR] indicated Klonopin .25 mg was given twice a day until increased to .5 mg on 11/24. The MAR indicated Xanax .5 mg was given for anxiety and agitation on 11/11, 11/15, 11/18, 11/22, and 11/30/10. The Behavior/Intervention Monthly Flow Record for November 2010 indicated the behaviors being monitored were resisting care and refusing to wear hearing aides. The record indicated the resident had only one day in November, 11/8/10, she exhibited any of the behaviors being monitored. Review of November 2010 nurses notes failed to indicate any display of behaviors on 11/15, 11/18, 11/22 or 11/30 when the Xanax was given. The 11/11 nurses notes indicated at 4 a.m. the resident was getting out of bed, removing alarm, and had confused conversation.	F 250	***practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Resident #83 nor any other resident will have a room change without proper notification. A "look back" audit has been done to review/reasons all residents who receive psychoactive drugs. These records have been reviewed by nursing administration, Social Services Director, Activity Director, Dietary Director, Pharmacy Consultant and physician. These records were reviewed to see that the least amount of psychoactive meds are being given and only after other non-medicine interventions are tired. Dose reductions must be considered. The DON or designee will monitor residents who receive meds for behaviors three times weekly to se that interventions have been tried and documented prior to med administration and also that behaviors are specific on Behavior Monitoring sheet. Any concerns will be immediately addressed. These monitorings will continue until four consecutive weeks of zero negative findings are realized. After this, random weekly monitorings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 44 The December 2010 MAR indicated Xanax was given: 12/1 at 1 AM and 9 AM for increased anxiety and exit seeking 12/3 for fearful and anxious 12/14 increased anxiety 12/27 increased anxiety written on back of MAR 12/29 increased anxiety tearful, exit seeking written on back of MAR The Behavior/Intervention Monthly Flow Record for December 2010 indicated the behaviors were the same as for November and the resident had only exhibited these behaviors on 12/1/10 and 12/14/10. Nurses Notes for December 2010 indicated the resident only displayed these behaviors on 12/3. Klonopin .5 mg twice a day was given the month of December 2010. A MD progress note, dated 12/30/10, indicated "Anxious c [with] improved control c (increase) in Klonopin dose. No GDR [gradual dose reduction]. It would be harmful to pt [patient]. Pharm [pharmacist] rec re [recommendations regarding] GDR Klonopin but dose recently increased due to break through anxiety." Review of the current MAR dated 1/2011, indicated Xanax given PRN: 1/1 at 8 a.m., tearful 1/12 at 7 a.m., tearful wanting to go home 1/19 8 a.m. 1/21 8 a.m. tearful, husband coming to get her The Behavior/Intervention Monthly Flow Record	F 250	will continue. Further, all records were reviewed to see that the residents long term plans are currently reflect dint heir care plan and that if they have changed from the long-term care plan on admission they have been discussed with the resident and are correctly reflected in the discharge plan documentation. Further, if the resident needs any help accepting long-term placement, the Social Service Director will facilitate any needed counseling, Discharge plans will be reviewed monthly by the SSD to see that they are still appropriate and that the resident is aware and agrees with the plan or proper steps will be initiated to achieve acceptance and agreement. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held February 15, 2011 the following was covered: a. Necessity to notify resident of room changes timely and appropriately b. Assessment for psychoactive meds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 45 for January 2011 indicated the behaviors resists care, refuses to wear hearing aide and anxiety - yelling to go home were monitored. Documentation indicated 1 on 1 and activity were the interventions tried on 1/12, 1/ 19 and 1/21 on the day shift. Interview with SS #1 and #2 on 1/27/11 at 3:40 p.m., indicated SS #1 was new to the job and was not aware she was to be involved with psychoactive medication review. She had never looked at the behavior monitoring sheets. SS #2 indicated social services was to monitor the use of psychoactive drugs and be a part of the care planning process. 3. The clinical record of Resident #91 was reviewed on 1/26/11 at 11:00 a.m.. The resident was admitted to the facility on 9/18/10, with plans to return home after rehabilitation. A care plan, dated 9/20/10, indicated the following: "Resident will discharge from facility after completion of therapy and physician's order." The goal was for the resident and family to be involved in care plan/discharge process through next review. Approaches included the following: Coordinate needed equipment for discharge Encourage family involvement in the activities of the facility Encourage family support for facility rules and regulations Invite resident and family to care plan and discharge meetings as scheduled Make needed referrals to community services Notify MD for needed discharge orders. There had been no changes in the resident's plan	F 250	c. Behavior monitoring d. Interventions prior to med administration e. Unnecessary drugs f. Discharge planning g. Resident involvement in care plan Any staff who fail to participate and comply with the points of the in-service will be further educated and/or progressively disciplined as needed. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the room changes will be reviewed. Also, the monitoring of med administration by the DON or designee for behaviors will be reviewed. Further, the monitoring of accurate discharge plans being in place by the SSD will be reviewed. Any concerns will be addressed. If necessary an action plan will be written by a committee appointed by the Administrator. The plan will be monitored weekly by the Administrator until resolution. **COMPLETION DATE: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 46 of care related to discharge. A Social Service progress note, dated 10/21/10, indicated a care plan conference was held to discuss the resident and her current progress and needs as well as potential discharge plans. The note indicated the resident's daughter attended the conference. The plan indicated the resident was told she needed to work hard on getting stronger, as well as increase her nutrition in order to go back home with the daughter. The conclusion of the note indicated therapy would work with her for another two weeks and the team would meet again on November 5, 2010 to talk about how she has progressed. "Will continue with current plan of care." Social Service notes on 11/5/10 note indicated "...She is a full code and plans to return home [with] daughter on the 12th. Family is picking HH (home health) company. Will f/u (follow-up) as needed." A Care Plan Conference note, dated 11/5/10, indicated daughter will brainstorm and keep us posted as therapy believes she will need 24 hour care for her safety and the note indicated the resident might need to go to another family member's home. The care plan remained unchanged and indicated discharge home was still the goal. A Social Service note, dated 11/22/10, indicated the staff member met with the resident for a 90 day assessment. According to the note, the resident was usually understood and appropriately answered questions. "Family plan is for her to remain in long-term placement. Will	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 47 continue with current plan of tx (treatment)." There was no change in the care plan and no indication the staff had addressed the change in plan with the resident. A Social Service note, dated 12/10/10, indicated the plan was for the resident to remain in long-term care and "Will continue current plan of care." There was no change in the care plan at this time and no indication the staff had addressed the change in plan with the resident. The quarterly Minimum Data Set (MDS) assessment, with assessment reference date of 12/10/10, indicated the following: Mood - Feeling down, depressed, or hopeless present 2-6 days (several days) Feeling tired or having little energy present 2-6 days A physician's progress note, dated 12/10/10, indicated the resident was exhibiting increased signs and symptoms of depression and the resident's anti-depressant medication was increased at that time. On 1/27/11 at 3:55 p.m., the Social Service indicated during interview that she was surprised when she learned Resident #91 wasn't going home and it was like "dropping a hatchet on her; has taken a hard toll on her." At this time, the Social Service consultant indicated that depending on her payer type, they could contact an outside agency for referral. 3.1-34(a)	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident rooms and resident common areas were clean and sanitary. This was observed in 21 resident rooms and affected 27 of 40 residents in the Stage 1 sample and affected various portions of 3 of 3 units during the environmental tour. Findings include: 1. Rooms 133 was observed on 1/24/11 at 3:44 p.m. The bathroom door was scraped. The wall by the soap dispenser in the bathroom was marred. 2. Room 114 was observed on 1/24/11 at 3:00 p.m. The walls in the room were missing paint in areas and the bathroom door was noted with areas of chipped paint. 3. Room 132 was observed on 1/24/11 at 2:53 p.m. The bathroom walls and door frame were noted with areas of paint scraped off and the wall was marred behind the chair in the room. 4. Room 106 was observed on 1/24/11 at 2:37 p.m. The dresser and bed finishes were scratched/marred. 5. Room 223 was observed on 1/25/11 at 9:38	F 253	**F 253** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that housekeeping and maintenance services are provided to provide a sanitary, orderly and comfortable environment for the residents. The following have been repaired/cleaned/replaced as indicated. Room 133 Bathroom door scrape. Wall by soap dispenser marred. Room 114 Walls missing paint Bathroom door chipped paint. Room 132 Bathroom walls/door frame scraped. Wall marred behind chair. Room 106 Bed/Dresser finishes scratched. Room 223 Urine odor. Commode extender legs rusted. Dresser scraped/ marred. Room 130 Wall scraped Wall around soap dispenser unfinished Rust bathroom door	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 49 a.m. A urine odor was noted in the room. The bathroom door frame was soiled at the base with a brown substance. The commode extender legs were rusted. A dresser in the bedroom was scraped/marred. 6. Room 130 was observed on 1/25/11 at 9:23 a.m. The wall was scraped don the plaster in areas. The wall around the soap dispenser in the bathroom was unfinished. There were areas of what appeared to be rust on the bathroom door frame. 7. Room 119 was observed on 1/24/11 at 3:06 p.m. The paint was chipping on the door frame to the bathroom. The chair by the dresser was noted with chipped paint in areas. 8. Room 217 was observed on 1/25/11 at 9:22 a.m. The bathroom grout in the floor tile was discolored. There was a dark discoloration of the tile at the threshold. 9. Room 125 was observed on 1/24/11 at 3:13 p.m. The bathroom walls were patched with spackle. The toilet seat was rusted at the connector bolts. 10. Room 233 was observed on 1/25/11 at 11:45 a.m. The bathroom door was observed with chipped paint in several areas. 11. Room 222 was observed on 1/25/11 at 8:55 a.m. The wall at the head of the bed was observed with the paint surface marred. 12. Room 104 was observed on 1/25/10 at 10:19 a.m. A portion of the cove base was missing in the bathroom. There was soap running down the	F 253	frame. Room 119 Bathroom door frame paint chipped. Chair by dresser had chipped paint. Room 217 Bathroom grout floor file discolored, dark discolored tile at threshold. Room 125 Bathroom walls patch spackle no paint. Toilet seat rusty bolts Room 233 Bathroom door chip paint. Room 222 Wall head of bed marred. Room 104 Cove base missing in bathroom. Soap running down wall to floor. Bathroom soil build-up edge of walls. Room 220 Night stands marred Baseboard pulling away near a/c. Door facing bathroom door soiled at base. Room 115 Chipped paint bedside white chair. Headboard/footboard bed scuffed. Room 134 Bathroom has urine/ musty odor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 50 wall with a build-up on the floor. The bathroom tile had soil build-up around the edge of the walls. 13. Room 115 was observed on 1/25/11 at 9:21 a.m. There was chipped paint on the bedside white chair. The headboard and footboard of the bed was scuffed/marred. 14. Room 220 was observed on 1/25/11 at 9:50 a.m. The night stands were marred. The baseboard was pulling away from the wall near the air conditioner. The door facing of the bathroom door was soiled around the left base of the door. The baseboard was missing in part of the bathroom. 15. Room 134 was observed on 1/25/11 at 11:46 a.m. The bathroom was noted with a urine/musty odor. The cove molding on the floor behind the toilet appeared discolored/moldy. 16. Room 232 was observed on 1/25/11 at 11:05 a.m. The corner of the wall outside the bathroom was white with rough plaster on a smooth beige wall. The wall around the soap dispenser was not refinished after placement of a different size dispenser. 17. Room 215 was observed on 1/24/11 at 3:49 p.m. The floor tile in the shower area had a gray residue around the drain. The tile behind the toilet was missing 5 squares of tile. The wall going into the shower was missing paint along both edges. The wall behind the head of the bed was scuffed/marred with an approximate 4 by 6 inch area of missing green paint. 18. Room 227 was observed on 1/24/11 at 3:54 p.m. The interior of the bathroom door was	F 253	Cove molding behind Toilet discolored. Room 232 Corner of wall outside bathroom white rough plaster. Wall around soap dispenser not finish. Room 215 Floor tile shower gray residue by drain. Tiles behind toilet missing 5 squares tiles. Wall at shower entry missing paint both sides. Wall behind head of bed scuffed/marred Room 227 Interior bathroom door marred. Tiles into bathroom broken. Wall behind bed marred. Room 204 Bathroom door frame marred. Unpainted areas wall around shower. Room 231 Wall behind bed marred. Urine odor dining rm Urine odor 100-111 Main dining Room: Quarter round broken off wall toward kitchen.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 51 marred with areas of paint missing. The tiles into the bathroom were broken. The wall behind the bed was marred. 19. Room 204 was observed on 1/25/11 at 12:21 p.m. The bathroom door frame was marred with areas of missing paint. There was unpainted areas of the wall around the shower. 20. Room 231 was observed on 1/25/11 at 11:35 a.m. The wall behind the bed was marred. The door facing to the bathroom was missing areas of paint. 21. During the initial tour of the facility, on 1/25/11 at 9:30 a.m., a urine odor was noted in the dining room and 100 - 111 hallway. The Assistant Director of Nurses agreed it smelled of urine. The following observations were made during the environmental tour of the facility: 22. The following was observed in the main dining room on 1/27/11 at 8:15 a.m. The quarter round was broken off on the wall toward the kitchen, exposing bare wood. The end of the baseboard toward the kitchen door was unfinished, with bare wood exposed and the purchase slip still stapled to the end of the wood. There was a build-up of soil in the thresh hold of the door to the room. The fireplace mantle was soiled with dirt, dust, and spills. The base bricks of the fireplace were soiled with debris and dirt/dust. The chair rail around the room was soiled with a heavy accumulation of dust/dirt. The baseboard was soiled with dirt/dust, and paint spills. The windows on the left side of the dining room were soiled with dirt/dust and had areas of	F 253	Baseboard toward kitchen door unfinished with purchase slip still stapled to end. Build up of soil in thresh hold of door. Fireplace mantle had dirt, dust, and spills Base bricks of fireplace soiled. Chair rail around room soiled. Baseboard soiled, paint spills. Window left side of room soiled, chipped paint. Two of eight tables uneven and rocked. Cabinet missing paint around door knob. Door knob on cabinet loose. Door to kitchen marred near base. Dietary staff propped door open with cart. Door banging into cart as staff enter/exit. Room 117 BM odor in bathroom (soiled wipes in trash) Skilled Shower Room: Mismatched tiles in stall. Build up soil around perimeter tiles. Small shower chair-rust on legs. Stand up lift heavily soiled. Handwashing sink away from wall-cracked caulking. Missing wall tiles left wall. Edge of privacy curtain soiled. Secured Unit: Exit door-gap bottom-left side (1/2 inch allowing cold air in) Wall above this exit door unpainted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 52 chipped paint. Two of 8 tables were uneven and moved/rocked when touched. One resident bumped her wheelchair into table she was using and caused the table to move while she was eating. The cabinet holding clothing protectors had an area of missing paint around the doorknob on the right side and the right door was loose at the top hinge, causing door not to fit properly and hang down. The door to the kitchen area was marred near the base of the door, with chipped paint and black streaks on door. Dietary staff were observed to prop the door open with a cart and take dirty items from dining room, letting the door bang against the cart each time they entered/exited. 23. On 1/27/11 at 11:06 a.m. Room 117 was noted with a strong urine and BM odor in the bathroom. There were wipes soiled with brown substance in the open trash can. 24. On 1/27/11 at 11:15 am the following was observed in the Skilled shower room: One shower stall had mismatched tiles and build-up of soil in floor tiles and around perimeter of shower stall. One small shower chair was observed with rust and corrosion buildup on all legs. The stand-up was lift heavily soiled in foot platform with dried dirt/debris. The handwashing sink was pulled away from the wall with cracked caulking. There was missing wall tiles on the left wall after entering the shower room. The edge of the privacy curtain was soiled with a black substance. 25. On 1/28/11 at 10:07 a.m., the secured unit exit door to the outside was observed with a gap	F 253	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Going forward the Corporate Hskg/Land/ Maintenance Director will review the Preventive Maintenance Manual to see that all areas of maintenance are covered and concerns are addressed. This person will make full facility rounds weekly in the building and will submit areas of concern to the Administrator. These weekly rounds will be ongoing. Action plans to address the issues found will be written as indicated and monitored weekly by the Corporate Consultant and the Administrator. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held February 15, 2011 the process of filling out a maintenance request when areas of disrepair or broken tiles and so on are noticed. The	

F 253 Continued
maintenance supervisor/staff will be responsible to address these issues. Any non-compliance will be met with further education and/or progressive discipline.

Element #4

How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date

At the monthly Quality Assurance meetings the results of the Corporate Hskpg/Laundry/Maint. Director's rounds will be reviewed. Also, any action plan progress will be reviewed. The Administrator will monitor all action plans to completion.

Completion Date: 02/27/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 53 on the left bottom side, approximately 1/2 inch, allowing cold air to come in. A portion of the wall above this exit door had been refinished and had white plaster unpainted.	F 253		
F 272 SS=D	3.1-19(f) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	**F 272** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** (See Response Element #1 F250) **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** (See Response Element #2 F250) **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** (See Response Element #3 F250) **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** (See Response Element #4 F250) **COMPLETION DATE: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were completed for problems identified on the Minimum Data Set assessments regarding psychoactive drug use for 1 of 9 residents reviewed for psychoactive drug use in the Stage 2 sample of 44. (Resident #5). The finding includes: 1. Observation on 1/26/11 at 8:35 a.m. indicated Resident #5 sat at breakfast feeding herself. Interview with the resident on 1/27/11 indicated she could state her name, where she was from and would be available for further interview. The resident was relaxed, aware of her surroundings and responded to questions appropriately. Record review on 1/25/11 indicated an 8/20/10 admission assessment for the use of psychoactive drugs, Klonopin and Xanax for depression, anxiety, increased confusion, and wanting to leave the facility. There were no further psychoactive drug assessments, even though there had been another Minimum Data Set assessment on 10/11/10 for readmission to the facility. The Medication Administration Record [MAR], dated November 2010, indicated Clonazepam was given .25 mg twice daily until 11/24 when it was increased to .5 mg twice daily. Xanax .5 mg, for anxiety and agitation, was given on 11/11, 11/15, 11/18, 11/22, 11/30/10. The MAR dated December 2010, indicated Xanax	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 55 was given: 12/1 at 1 AM and 9 AM for increased anxiety and exit seeking. 12/3 for fearful anxious 12/14 increased anxiety 12/27 increased anxiety 12/29 increased anxiety tearful, exit seeking Clonazepam was given .5 mg bid the month of December 2010 The current January 2011 MAR indicated Xanax was given: 1/1 at 8 AM tearful 1/12 at 7 am tearful, wanting to go home 1/19 at 8 am tearful, wanting to go home 1/21 at 8 am tearful, husband coming to get her Interview with LPN #1 indicated the resident needed the psychoactive medication due to becoming very tearful, exit seeking, depressed, and during these times, she was not easily redirected. Interview with SS #1 and SS #2 on 1/27/11 at 3:20 p.m. indicated the social service staff had not been involved in the assessment of Resident #5 regarding psychoactive drug use. SS #1 had just been told on 1/27/11 that involvement in the assessment process was part of her responsibilities. 3.1-31(c)(13)	F 272	**F 273** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to conduct a timely assessment within 14 calendar days of admission and develop a comprehensive care plan. As indicated in the survey Resident #109 has had an MDS completed. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. Going forward the DON/designee and/or MDS Consultant will monitor all new admits/readmits to see that a 14 day assessment is completed as well a care plan. Any concerns will be immediately addressed. This monitoring will be ongoing.	
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which	F 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 56 there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set assessments were completed by the 14th day following admission for 1 of 18 residents whose clinical records were reviewed in the Stage 2 sample of 44. (Resident #109) The finding includes: Record review on 1/25/11 indicated Resident #109 was admitted to the facility on 1/3/11. There was no Minimum Data Set [MDS] assessment on the clinical record. Interview with the MDS nurse on 1/28/11 indicated she did not have an admission assessment completed on Resident #109. She knew it was due and had not completed it yet. At 4:20 p.m., the MDS nurse provided a completed MDS for Resident #109, dated 1/10/11. Interview at the time indicated the software program would not let her enter a date that was beyond the due date. 3.1-31(d)(1)	F 273	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held February 15, 2011, the requirements of a 14 day assessment and care plan being completed foe each resident was reviewed. Further, the role of the MDS Coordinators was reviewed with them for timeliness of the MDSs. Any staff who fail to comply with their role in the points of the in-service will be further educated and/or progressively disciplined as appropriate. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitorings of the MDS/care plans by the DON/designee and/or the MDS Consultant will be reviewed. Any patterns will be identified. If necessary an action plan will be written by a committee appointed by the Administrator. The plan will be monitored weekly until resolution. **COMPLETION DATE: 02/27/11**	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 57 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans were developed and/or revised as conditions changed to ensure they included measurable timetables to meeting the residents' needs. This affected 6 of 18 residents whose clinical records were reviewed in the Stage 2 sample of 44 residents. (Resident #91, #56, #108, #5, #109, #3) Findings include: 1. The clinical record of Resident #91 was reviewed on 1/26/11 at 11:00 a.m.. The resident was admitted to the facility on 9/18/10, with plans to return home after rehabilitation.	F 279	**F 279** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to conduct a timely assessments and to use the results of these assessments to develop a comprehensive plan of care. Resident #91 has had their care plan updated and it is current. The plan has been discussed with her. She is being seen by the facility's psych. Provider to work through the fact that she will not be returning to her home. Resident #56's care plan has been updated to address her cellulitis concerns. Resident #108 has the pressure mattress properly addressed on the care plan. It is being checked every shift and documented. The hose is fixed. Resident #5's care plan has been addressed and reflects behaviors with measurable goals. Resident #109's care plan has been reviewed and currently addresses any concerns including falls or lacerations. These are measurable goals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 58 A care plan, dated 9/20/10, indicated the following: "Resident will discharge from facility after completion of therapy and physicians order." The goal was for the resident and family to be involved in care plan/discharge process through next review. Approaches included the following: Coordinate needed equipment for discharge Encourage family involvement in the activities of the facility Encourage family support for facility rules and regulations Invite resident and family to care plan and discharge meetings as scheduled Make needed referrals to community services Notify MD for needed discharge orders. The had been no changes in the resident's plan of care related to discharge. A Social Service note, dated 11/22/10, indicated the staff member met with the resident for a 90 day assessment. According to the note, the resident was usually understood and appropriately answered questions. "Family plan is for her to remain in long-term placement. Will continue with current plan of tx (treatment)." There was no change in the care plan and no indication the staff had addressed the change in plan with the resident. A Social Service note, dated 12/10/10, indicated the plan was for the resident to remain in long-term care and "Will continue current plan of care." There was no change in the care plan at this time	F 279	Resident #3's care plan currently addresses all of her current concerns with measurable goals. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. A facility wide audit was conducted to see that all current concerns are on the resident's care plan and that they have measurable goals. Going forward, the DON/designee will check 10 care plans weekly to be certain they are current and have measurable goals. This monitoring will be ongoing. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held February 15, 2011, the importance of timely, accurate care plans with measureable goals was discussed. The nursing staff's role was addressed as to adding to the care plans. Any staff who fail to comply with the points of the in-service will be further educated and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 59 and no indication the staff had addressed the change in plan with the resident. On 1/27/11 at 3:55 p.m., the Social Service indicated during interview that she was surprised when she learned Resident #91 wasn't going home and it was like "dropping a hatchet on her; has taken a hard tole on her." At this time, the Social Service consultant indicated that depending on her payer type, they could contact an outside agency for referral. 2. Resident #56's clinical record was reviewed on 1/26/11. Her diagnoses included, but were not limited to, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus. A physician's order, dated 1/4/11, indicated a diagnosis of lower extremity cellulitis. The order also included an order for "1) wound care to LE's (lower extremity) ulcerations, 2) above the knee ace wraps to LE (lower extremities) (above knee) 3) Cipro (antibiotic) 500 mg (milligrams BID (twice daily) x (for) 14 days. . ." A physician's order, dated 1/14/11, indicated the following: "(L) (left) leg open area - Santyl (debridement agent) dly (daily) Cover & secure. Have wound team look @ (at) legs." The first wound care specialist note provided for review was dated 1/21/11 and indicated treatment/assessment of a vascular are on the left great toe. The care plan, dated 1/8/11, indicated the problem of edema but was not revised to include	F 279	progressively disciplined as appropriate. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meeting the monitoring of the care plans by the DON/designee will be reviewed. Any concerns will have been addressed upon discovery. **COMPLETION DATE: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 60 the diagnosis of cellulitis or the development of the vascular areas on the lower extremities. 3. Record review on 1/25/11 indicated Resident #108 was admitted from the hospital on 1/19/11 with pressure ulcers. There were two unstageable pressure ulcers on bilateral heels and a Stage 3 pressure ulcer on the left ischium. A care plan had been started upon admission for the pressure ulcers. One intervention was "low air loss mattress." There was no indication what settings were to be used for the resident, or any special instructions to ensure proper functioning. The Treatment Administration Record included to check the pressure relieving mattress on the bed every shift. There was no indication what was being checked. Observation and interview with the resident on 1/27/11 indicated the mattress was going flat when a hose popped off repeatedly. Interview with CNA #1 and LPN #3 indicated the problem had been brought to their attention prior to this date when the resident told them what was happening with the mattress. 4. Clinical record review on 1/25/11 indicated Resident #5 was admitted to the facility in August 2010. The 8/20/10 admission assessment indicated Klonopin and Xanax were given for depression, anxiety, increased confusion and wanting to leave. A care plan, dated 8/25/10 and current through 2/23/11 addressed the problem, at risk for adverse side effect from the psychoactive drug use. The goal for the problem was, "Anxiety will be	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 61 controlled through use of medication." There was no care plan for the problem of the behavior with measurable goals. 5. Clinical record review on 1/25/11 indicated Resident #109 had fallen on 1/9/11 and was treated for a laceration on the forehead. On 1/9/11 at 4:30 p.m., a nurses note indicated a laceration to the forehead, and the resident was sent to the Emergency Department and returned to the facility at 11:30 p.m. An assessment of the laceration and bruises upon return from the Emergency Department did not include measurement or description. The notes indicated there were "multiple bruises on the face around her L [left] eye." On 1/10/11 at 11:00 a.m., an assessment indicated, "Res c [with] bruising throughout face - top of head, R [right] arm and hand - R hip, knee and LE's [lower extremities] , R knee warm to touch, slightly pink." On 1/11/11 at 10:00 a.m. an assessment indicated, "...sutures and staples to head intact, bloody areas to head, bruising to r knee & leg & arm..." There was no care plan which addressed the problem of the laceration, which required sutures and staples to the head, or bruises. 6. Resident # 3 was interviewed on 1/24/11 at 2:30 p.m. concerning pain. She indicated she had pain with no relief. Her face had several heavy dark scabs on it and her left eye was swollen and red. The resident indicated she had "chicken pox in her eye." She indicated the pain was very bad.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 62 Interview with Resident # 3, at 2:00 p.m. on 1/26/11, indicated she had not been able to get a pain pill because she was on a schedule. She stated, "When I want a pain pill, I need it right now." She indicated she also was aware she could have Tylenol every four hours when I need it through the night. The care plan was reviewed on 1/26/11 at 9:30 a.m.. The documentation indicated the care plan had been reviewed on 11/4/10. Areas addressed on the care plan included: potential for infection related to diagnoses of chronic bacteruria; therapeutic diet and weight loss; altered skin integrity secondary to diagnosis of seborrheic dermatitis; short term memory loss; diagnosis of anxiety; diagnoses of depression and schizophrenia; use of antipsychotic drugs; adl (activities of daily living) deficit; cardiac stress related to diagnoses of high blood pressure and history of stroke; constipation risk; fall risk; potential for pain related to diagnoses of lumbar back pain, osteoarthritis, and risk factors of depression; foot care related to dry skin; and activities deficit. There was no care plan or any interventions included in related areas to address the shingles infection. The Minimum Data Set Nurse was interviewed on 1/27/11 at 10:00 a.m. She indicated the floor nurses were to address the acute assessment and writing the care plan for acute issues like shingles.	F 279		
F 282 SS=D	3.1-35(a) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 63 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans were followed including use of a gait belt and pain management. This affected 1 of 3 residents reviewed for falls and 1 of 3 residents reviewed for pain management in the Stage 2 sample of 44 residents. (Resident #56, #3) Findings include: 1. During interview of the nurse caring for Resident #56 on 1/25/11 at 2:18 p.m., she indicated the resident had sustained a fall in the past 30 days which resulted in a skin tear and a bump on the back of the head. The nurse indicated the resident was sent to the emergency room for evaluation when the fall occurred on 1/17/11. Resident #56's clinical record was reviewed on 1/26/11. According to the care plan, "At risk for falls related to Hx (history) of falls prior to admission) printed 1/5/11, the resident experienced a fall on 12/29/10 "assisted." The care plan was unchanged following this fall and a second fall occurred on 1/17/11, "assisted." The goal indicated, "Resident will not substain (sic) a significant injury from falls, thru next review." Approaches included, but were not limited to, "Assist of 1-2 for transfers, with gait belt."	F 282	**F 282** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to se that services are provided or arranged by qualified persons in accordance with each resident's plan of care. Currently, Resident #56 is cared for by staff who use all proper devices or techniques. Currently, Resident #3 has her pain relief needs met. She is asked to rate pain on a scale of one to ten. After pain med administration, she is checked so that effectiveness of the med is evaluated. Should themed be ineffective the physician is notified for a change of intervention. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. A "look back" audit was done to identify all residents who require assist "to"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 64 Nurses notes indicated the following: 1/17/11 7:30 a.m. "Aide was in resident's room at app (approximately) 6:45 A (a.m.) attempting to get resident's weight when aide assisted resident to step back and set on bed. Resident stepped sideways instead and fell to the floor, writer was (illegible word) walking into room as saw resident fall backwards and hit the floor butt first. Later her head fell back and hit the wall, resident remained concous (sic). . .Resident has 4 cm (centimeter) wound and some puncture wounds on upper (R) (right) arm and (R) hip [with] serosanguinous drainage. . ." On 1/24/11 at 3:30 p.m., during discussion of Resident #56's fall with the Director of Nursing (DON), she indicated the CNA failed to use a gait belt during the resident's fall on 1/17/11 and she was terminated. Documentation indicated "(Name of CNA) was transferring resident (Name of Resident #56) in the morning she was not using a gait belt as per our policy. Resident (#56) fell hitting her head, resident was then sent to. . ." 2. Resident # 3 was interviewed on 1/24/11 at 2:30 p.m. concerning pain. She indicated she had pain with no relief. Her face had several heavy dark scabs on it and her left eye was swollen and red. The resident indicated she had "chicken pox in her eye." She indicated the pain was very bad. Interview with Resident # 3, at 2:00 p.m. on 1/26/11, indicated she had not been able to get a pain pill when she needed it because she was on a schedule. She stated, "When I want a pain pill, I need it right now." She indicated she also was aware she could have Tylenol every four hours when she needed it through the night.	F 282	residents who require assist "to" transfer, including gait belts. A facility wide "look back" audit was conducted to identify residents who receive pain medications. The DON or designee will monitor 10 residents daily three days weekly on various shifts who require gait belt use for transfer to see that this is happening. Further, the DON or designee will monitor ten residents three days weekly on various shifts who receive pain medications to see that they are receiving relief and that nurses are (1) scaling pain on a one to ten scale as told or displayed for effectiveness of pain med. This monitoring will continue until four consecutive weeks of zero negative findings are realized. Then random checks will be made. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff in-service held February 15, 2011, the importance of using any and all safety devices such as gait belts during transfers was reviewed. Further, the necessity of evaluating pain on a one to ten scale then checking to se that pain relief takes place after pain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 65 During an 1/27/11 at 10:30 a.m. interview, Resident #3 indicated the nurses did not ask her to rate the pain on a scale nor did they return to check for effectiveness. The clinical record was reviewed on 1/26/11 at 9:30 a.m. The care plan, dated as reviewed on 11/4/10, indicated the following interventions for pain were to be used: "address c/o (complaints of) pain, or indication of pain, promptly with meds; administer medications as ordered for pain relief; assess effectiveness of pain medication; assess for possible depression; assess pain characteristics: duration, location, quality; assess present pain coping strategies; assist to position for comfort as needed; diet as ordered; divert attention through activities as tolerated; encourage fluids; encourage to discuss feelings of frustration, anxiety, fear; encourage to report any pain; labs as ordered; notify MD for signs/symptoms of GI (gastro-intestinal) distress; observe of increase in anxiety, report to nurse as noted; reinforce positive pain coping behavior; report diaphoresis, moaning, restlessness, grimace, crying; report increase in b/p (blood pressure) or pulse; and teach importance of early intervention to pain." The Medication Administration Record (MAR) for January 2011 was reviewed. The hydrocodone pain medication was ordered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Tylenol 650 milligrams was also ordered every four hours as needed through the night. The pain medication was initialed as having been given, but there was no indication of how the resident had rated the pain or how effective the scheduled pain medication had been.	F 282	medications is administered by nurses was discussed. Any staff who fail to perform their role in the points of the in-service will be disciplined up to and including termination. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitoring of gait belt use and pain evaluation as far as severity on a one to ten scale, then relief after pain reliever is administered will be reviewed. Any concerns will have been addressed upon revelation by DON or designee. **COMPLETION DATE: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 66 Interview with LPN # 7, at 2:00 p.m. on 1/27/11, indicated the staff were supposed to have the resident rate the pain on a scale from one to ten, with ten being the worst. The staff then could go back in fifteen minutes to find if the pain had decreased in scale or not. This process should be repeated at one hour, then two hours. If the pain had not decreased in scale, then the doctor might need to be notified for a different medication or a change in the schedule. 3.1-35(g)(2)	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were assessed frequently with changes in condition to ensure they received the necessary care and treatment to promote healing of areas and control pain associated with shingles. This affected 1 of 1 resident reviewed with cellulitis, 1 of 2 residents reviewed with bruising, and 1 of 3 residents reviewed for pain management in the Stage 2 sample of 44. (Resident # 56, #3, #109) Findings include:	F 309	**F 309** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to se that each resident receives care and services to promote their highest well-being. Currently, Resident #56's clinical record includes assessing of any edema or cellulitis or weeping of legs or shortness of breath. Henceforth, Resident #109's clinical record will include assessments including measurements of any bruises or lacerations anywhere on the body. Resident #3 has her pain rated on a scale of one to ten for severity. Further, nurses check back and document effectiveness of any pain meds. If pain is not relieved, the physician is notified for another intervention.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 67 1. During interview on 1/28/11 at 11:15 a.m., Resident #56 indicated the facility was treating areas on the left leg and toe and they were possibly due to edema. The resident indicated she has had weeping from her legs and arm since her admission here. Resident #56's clinical record was reviewed on 1/26/11. Her diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus. A physician's order, dated 1/4/11, indicated a diagnosis of lower extremity cellulitis. The order also included an order for "1) wound care to LE's (lower extremity) ulcerations, 2) above the knee ace wraps to LE (lower extremities) (above knee) 3) Cipro (antibiotic) 500 mg (milligrams) BID (twice daily) x (for) 14 days. . ." A physician's order, dated 1/14/11, indicated the following: "(L) (left) leg open area - Santyl (debridement agent) dly (daily) Cover & secure. Have wound team look @ (at) legs." The first wound care specialist note provided for review was dated 1/21/11 and indicated treatment/assessment of a vascular area on the left great toe. A "Consultation Report" dated 1/17/11 at 2:00 p.m. indicated physician's findings of, "Worsening edema" with an order for medication adjustment. Nurses notes did not consistently contain assessments of the resident's edema or cellulitis. Nurses notes indicated the following:	F 309	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by these findings. By using the 24 Hour Report and the Medication and Treatment Sheets, the DON or designee will monitor ten clinical records weekly to see that pertinent charting on acute conditions such as cellulitis, healing lacerations, or bruises, scaling of pain on a one to ten scale and so on are being done in a complete and detailed manner. Any concerns will be immediately addressed upon discovery. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** In an all staff in-services held February 15, 2011, the necessity of pertinent charting being done was reviewed. Ex: measurements of edema, lacerations, bruises, pain scale and so on. Pertinent, measurable charting was explained and how it was needed to make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 68 1/14/11 10:00 p.m. "Received n/o (new order) change Colace (stool softener) to 100 mg (milligrams) po (by mouth) daily for constipation. Treatment for (L) leg open area Santyl to wound bed, dry dressing cover and secure, have wound team evaluate. Will continue to monitor." The previous note on 1/14/11 at 10:00 a.m. did not address contacting the physician for changes in orders. The next entry related to the resident's edema was as follows: 1/17/11 9:15 a.m. ". . .edema +2 (two plus) to LE's (lower extremities) & (and) arms. . ." 1/17/11 8:00 p.m. ". . .Cont. (continues) on AtB (antibiotic) therapy for bil (bilateral) lower extremities cellulitis." 1/18/11 9:30 p.m. ". . .Cont (continue) note weeping to (Rt) (right) LEx's (lower extremities). . .AtB therapy Cipro completed (completed) for bil LEx's cellulitis." 1/19/11 (no time noted) ". . .Drsg (dressing) [changed] to (L) LE.. Drsgs [changed] to forearms. (R) arm continues to weep. Swelling noted to bilateral LEs. . ." 1/20/11 5:00 a.m. ". . .Tx (treatment) (L) LE. O/A (open are) [without] drainage. . ." 1/22/11 6:00 a.m. "New order received treatment to (L) great toe. . .Edema has [decreased] cellulitis remains (illegible word) same. . ." A Wound Specialist Progress Note, dated	F 309	judgments as to positive progress being made or not being made was explained. All staff who fail to comply with their role in the points of the in-service will be further educated and or progressively disciplined as needed. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitoring of Pertinent charting by the DON or designee will be reviewed. Any concerns will have been addressed upon revelation by DON or designee. **COMPLETION DATE: 02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 69 1/27/11, indicated two areas were evaluated/treated. One area was the left great toe, with a date of etiology "wk (week) of 1/21/11" and left lateral lower extremity with date of etiology "wk of 1/24/11." The diagnosis/plan indicated the resident had venous ulcer to left later lower extremity and left great tow. The plan for congestive heart failure was to "monitor edema." A care plan, dated 1/5/11, indicated the problem, "Has edema noted on bilateral lower ext's." The goal was for the "Presence of edema will be found through nursing assessment." Approaches included the following: "Encourage mild exercise daily, Encourage resident to change position frequently, assist as needed, Encourage resident to keep legs elevated when edema is present, Monitor labs as ordered, Notify MD (Medical Doctor) and family of SOB (shortness of breath), increased edema, any weeping or open areas, Treat presence of edema per doctors orders, Weekly skin assessments." Consistent assessment of the edema, presence/absence of weeping, and/or shortness of breath was lacking in the nurses notes. The Assistant Director of Nurses was asked for any assessments related to Resident #56's areas on 1/27/11 at 2:00 p.m. The above information/assessment was provided, and no additional information was provided prior to the exit conference on 1/28/11. 2. During observation of Resident #109 on 1/24/11 at 3:31 p.m., the resident had purple bruising under the left eye and on the right side of the neck.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 70 Record review on 1/25/11 of nurses notes on 1/9/11 at 4:30 p.m. indicated a laceration to the resident's forehead and transfer to the emergency department of the hospital. The resident was returned to facility at 11:30 p.m. the same day. The assessment of lacerations and bruises upon return did not measure or describe the color of the bruises, but noted, "multiple bruises on the face around her L eye." Nurses Notes dated: 1/10/11, 11 a.m. indicated, "Res c [with] bruising throughout face - top of head, R [right] arm and hand - R hip, knee and LE's [lower extremities], R knee warm to touch, slightly pink." 1/11/11, 10 a.m. note indicated, "...sutures and staples to head intact, bloody areas to head, bruising to r knee & leg & arm..." 1/11/11, 8:30 p.m. indicated, "cont [continue] note bruising to face, Uex's [upper extremities], et lower extremities. 1/12/11, 5 a.m. indicated "Facial discoloration continues." 1/13/11, 7 p.m. indicated "bruising to face beginning to dissipate." Nothing about bruising to extremities. 1/18/11, 7:30 p.m. indicated "Bruising to face, upper extremities and lower extremities..." 1/19/11, 8:45 a.m. "multiple bruising on lower extremities." 1/24/11, 8:15 p.m. "bruising to face - dissipating. Cont note old bruising to bil [bilateral] lat [lateral] lower extremities and edema to bil [bilateral]	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 71 lower extremities." (SIC) LPN #2 provided a skin book on 1/26/11 at 10:30 a.m., but there were no further assessments of the areas. A Weekly Skin Assessment Book was provided on 1/27/11 for review. There were weekly assessments of R Knee, L side head laceration, top lip and lower right leg. There were no assessments of the bruises. Interview with the ADON on 1/27/11 indicated the assessments would be in the nurses notes or assessment book. 3. Resident # 3 was interviewed on 1/24/11 at 2:30 p.m. concerning pain. She indicated she had pain with no relief. Her face had several heavy dark scabs on it and her left eye was swollen and red. The resident indicated she had "chicken pox in her eye." She indicated the pain was very bad. Interview with Resident # 3, at 2:00 p.m. on 1/26/11, indicated she had not been able to get a pain pill because she was on a schedule. She stated, "When I want a pain pill, I need it right now." She indicated she also was aware she could have Tylenol every four hours when I need it through the night. The clinical record was reviewed on 1/24/11. A care plan, reviewed on 11/4/10, indicated the following interventions for pain were to be used: "address c/o (complaints of) pain, or indication of pain, promptly with meds; administer medications as ordered for pain relief; assess effectiveness of pain medication; assess for possible depression; assess pain characteristics: duration, location, quality; assess present pain	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 72 coping strategies; assist to position for comfort as needed; diet as ordered; divert attention through activities as tolerated; encourage fluids; encourage to discuss feelings of frustration, anxiety, fear; encourage to report any pain; labs as ordered; notify MD for signs/symptoms of GI (gastro-intestinal) distress; observe of increase in anxiety, report to nurse as noted; reinforce positive pain coping behavior; report diaphoresis, moaning, restlessness, grimace, crying; report increase in b/p (blood pressure) or pulse; and teach importance of early intervention to pain." The Medication Administration Record (MAR) for January, 2011 was reviewed. The hydrocodone pain medication was ordered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. Tylenol 650 milligrams was also ordered every four hours as needed through the night. The pain medication was initialed as having been given, but there was no indication of how the resident had rated the pain or how effective the scheduled pain medication had been. Interview with LPN # 7, at 2:00 p.m. on 1/27/11, indicated the staff were supposed to have the resident rate the pain on a scale from one to ten, with ten being the worst. The staff then could go back in fifteen minutes to find if the pain had decreased in scale or not. This process should be repeated at one hour, then two hours. If the pain had not decreased in scale, then the doctor might need to be notified for a different medication or a change in the schedule.	F 309		
F 311 SS=D	3.1-37(a) 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 73 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident was given services and care planned to assist the resident in adjusting to long-term placement, once it was realized the resident would not be able to return home. This affected 1 of 4 residents reviewed for possible community discharge in the Stage 2 sample of 44. (Resident #91) Findings include: The clinical record of Resident #91 was reviewed on 1/26/11 at 11:00 a.m. The resident was admitted to the facility on 9/18/10, with plans to return home after rehabilitation. A care plan, dated 9/20/10, indicated the following: "Resident will discharge from facility after completion of therapy and physician's order." The goal was for the resident and family to be involved in care plan/discharge process through next review. Approaches included the following: Coordinate needed equipment for discharge Encourage family involvement in the activities of the facility Encourage family support for facility rules and regulations Invite resident and family to care plan and discharge meetings as scheduled Make needed referrals to community services	F 311	**F311** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that residents are given appropriate treatment and services to improve their abilities. Resident #91 will have foot rests on her wheelchair unless she needs them off to self propel. Further, therapy reported that resident would need 24 hour care for her safety. Since the family was not able to provide this 24 hour care the nursing home was felt to be the best option. Discussions for this placement were not well documented and did not contain the resident's input. The resident was not felt to be safe in a community setting independently. The facility's psych services provider is currently seeing the resident to help her accept placement. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 74 Notify MD for needed discharge orders. There had been no changes in the resident's plan of care related to discharge. A care plan, dated 9/20/10, indicated the resident was at risk for loss of ADL (activities of daily living) functional ability related to weakness, debility, and increased risk factors of diagnosis of Parkinson's Disease. The goal was for the resident to regain her prior level of independence by the end of her facility stay as evidenced by returning home. The care plan had been unchanged and remained current with review date of 3/19/11. Approaches included, but were not limited to, "W/C (wheelchair) for locomotion, staff to propel as needed." A Social Service progress note, dated 10/21/10, indicated a care plan conference was held to discuss the resident and her current progress and needs as well as potential discharge plans. The note indicated the resident's daughter attended the conference. The plan indicated the resident was told she needed to work hard on getting stronger, as well as increase her nutrition in order to go back home with the daughter. The conclusion of the note indicated therapy would work with her for another two weeks and the team would meet again on November 5, 2010 to talk about how she has progressed. "Will continue with current plan of care." Social Service notes on 11/5/10 note indicated "...She is a full code and plans to return home [with] daughter on the 12th. Family is picking HH (home health) company. Will f/u (follow-up) as needed."	F 311	All residents who have plans to return home after a short term stay but then do not return home have the potential to be affected by this finding. Going forward the Social Service Director will keep a list of residents who plan to return home. If those discharge plans start to change, the resident will be included in the discussions for placement. Community placement will be considered if feasible. The list will be reviewed biweekly by the Social Service Director and the Administrator and the Director of Nursing to see if the discharge plan in place is still feasible. This will be ongoing. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff inservice held on 02/15/11, the importance of helping the resident to receive all treatment and services to improve their abilities was discussed. The Social Services Director was reminded of her role to help resident to enjoy the most independent placement possible based on their abilities. This should be reflected in their discharge plan. The resident must be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 75 A Care Plan Conference note, dated 11/5/10, indicated daughter will brainstorm and keep us posted as therapy believes she will need 24 hour care for her safety and the note indicated the resident might need to go to another family member's home. The care plan remained unchanged and indicated discharge home was still the goal The resident was observed on 1/25/11 at 10:56 a.m. to be up in the wheelchair. She was being propelled by staff and had no foot rests on the wheelchair, causing her to have to lift her legs up for transport. During interview with the resident on 1/26/11 at 3:15 p.m., she indicated the lack of foot pedals on her wheelchair wasn't a problem "except when I have to hold them up" for transport. On 1/27/11 at 8:15 a.m., the resident was observed in her wheelchair in the dining room with socks on her feet. Her buttocks were slid down from the back of the wheelchair, causing her to slump down and her upper legs were out past the end of the wheelchair seat. She had to lift the entire weight of her legs when transported by staff. On 1/28/11 at 10:30 a.m. the resident was transported into the therapy department in her wheelchair and did not have foot rests/pedals in place. She had socks on and her feet were rubbing on the floor as she was pushed. During interview with the Assistant Director of Nurses on 1/28/11 at 11:00 a.m., she indicated the resident did self-propel in the wheelchair at	F 311	as much a part of their placement decision as possible. All of this planning must be well documented. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the biweekly meetings on discharge plans by the Social Service Director, Director of Nursing, and Administrator will be reviewed. Concerns will be addressed at the biweekly meetings. **Completed 02/27/2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 76 one time and didn't need foot pedals but physical therapy had picked her up on 1/26/11 related to wheelchair positioning and the thought they were going to put pedals on her wheelchair. A Social Service note, dated 11/22/10, indicated the staff member met with the resident for a 90 day assessment. According to the note, the resident was usually understood and appropriately answered questions. "Family plan is for her to remain in long-term placement. Will continue with current plan of tx (treatment)." There was no change in the care plan and no indication the staff had addressed the change in plan with the resident. A Social Service note, dated 12/10/10, indicated the plan was for the resident to remain in long-term care and "Will continue current plan of care." There was no change in the care plan at this time and no indication the staff had addressed the change in plan with the resident. The quarterly Minimum Data Set (MDS) assessment, with assessment reference date of 12/10/10, indicated the following: Mood - Feeling down, depressed, or hopeless present 2-6 days (several days) Feeling tired or having little energy present 2-6 days A physician's progress note, dated 12/10/10, indicated the resident was exhibiting increased signs and symptoms of depression and the resident's anti-depressant medication was increased at that time.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 77 On 1/27/11 at 3:55 p.m., the Social Service indicated during interview that she was surprised when she learned Resident #91 wasn't going home and it was like "dropping a hatchet on her; has taken a hard toll on her." At this time, the Social Service consultant indicated that depending on her payer type, they could contact an outside agency for referral. At this time, the Social Service Director and Consultant were asked to provide any additional information they could find regarding ensuring all possible avenues were explored for possible discharge. No additional information was provided prior to the exit conference on 1/28/11.	F 311		
F 314 SS=G	3.1-38(a)(1) 3.1-34(a)(3) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident did not develop a pressure sore on the heel following a hip fracture. The facility also failed to ensure a knee immobilizer was applied correctly	F 314	**F314** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that residents who enter the facility without pressure sores do not develop pressure sores unless their condition makes this unavoidable. Also, any resident who enters with a pressure sore receives treatment to promote healing. Resident #64 is currently healed from both his heel area and the areas on his leg caused by the immobilizer. Resident #108 is currently in the hospital.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 78 to prevent the development of a pressure sore related to the immobilizer placement and failed to promote healing of an area related to a specialty mattress. The facility also failed to ensure the physician was promptly notified of an area developing related to a knee immobilizer. This affected 2 of 2 residents reviewed for pressure sores in the Stage 2 sample of 44. This resulted in one resident developing an unstageable pressure ulcer to the heel and a stage 3 pressure ulcer to the right leg. (Resident #64, #108) Findings include: 1. During interview of the nurse caring for Resident #64 on 1/25/11 at 10:59 a.m., she indicated the resident had an unstageable ulcer to the heel. Resident #64's clinical record was reviewed on 1/25/11 at 10:59 a.m.. Documentation indicated the resident was readmitted on 9/30/10 after a hip fracture. The admission nursing assessment indicated the resident had no pressure sores on readmission. A 9/30/10 Braden assessment for risk of pressure sores indicated score of 15, with a total score of 12 or less representing high risk. A care plan, dated 10/12/10, identified a potential for pressure sores. The goal was for the resident to be free from pressure related skin concerns. The approaches did not include floating the resident's heels to ensure they were free of pressure. The care plan identified a right heel ulcer - pressure - unstageable on 10/21/10, with a goal for the area to decrease in size by .2 centimeters (cm) by next review. One approach was dated 10/29, for Promod (protein supplement) per orders, and a second entry,	F 314	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All the residents either admitted with a hip or an immobilizer in place or with a low air loss mattress (of this particular type) have the potential to be affected by this finding. An audit was done and a targeted list of all these residents was compiled. The Director of Nursing/Designee will monitor 5 days weekly on various shifts to see that: a. Hip fractures have the affected leg's heels "floated" b. Immobilizers are place on correctly including stretching prior to application if indicated. c. Low air loss bed functioning properly Documentation will be monitored also. This monitoring will continue until 4 consecutive weeks of zero negative findings is realized. Then random weekly monitoring will be done.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 79 following the 10/29 entry, indicated, "prevelon (sic) boots bilat (bilateral) @ (at) all x's (times)." The October 2010 Treatment Record included a notation, "Prevalon Boots bilaterally @ (at) all times (No Shoes)." Documentation on the treatment record indicated the boots were started on 10/21/10. The January 2011 Treatment Record included a notation, "Keep right heel elevted (sic)/not touching anything while in bed 2nd (secondary) to decub ulcer to heel (started 11/05/10)." A Wound Assessment Form indicated an open area was discovered on 10/12/10 to the right heel. The form indicated the size was .5 cm (centimeters) by .5 cm. A physician's order was dated 10/12/10 for Bacitracin to the open area with foam dressing. Nurses notes indicated the following: 10/12/10 4:00 a.m. "Blister noted to (L) (sic) heel, open. Put on MD (medical doctor) communication board. +3 edema (swelling) noted to RLE (right lower extremity), put on MD communication board/sheet." 10/12/10 4:00 a.m. "Res (resident) continent of bladder per foley cath (catheter). Incontinent of bowel." 10/13/10 1:00 a.m. N.O. (new order) upgrade diet to regular consistency & thin liq (liquids per Dietary. Pharmacy notified." 10/12/10 (sic) 11:30 p.m. Dr. (name) off (name) (NP) (Nurse Practitioner) was in fac. New order rec'd (received et (and) noted." 10/13/10 (no time indicated) Resident went out to Dr. (doctor) apt (appointment). LOA (leave of	F 314	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff inservice held on 02/15/11, the following was covered: a. Importance of "floating" the heel of the affected leg of a hip fracture to avoid pressure on the heel b. Following instructions for applying an immobilizer including following the schedule and doing any "stretching" out of the limb prior to application Note: only properly trained/qualified staff may apply any device c. Importance of low air loss beds functioning properly and reporting any malfunction immediately Any staff who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 80 absence). Dr. Findings: very stiff in muscles of both legs; xrays show (R) hip fracture is healing well; pinning of (R) femoral neck fracture. New orders: Daily PT (physical therapy) passive ROM (range of motion), stretching of both hips/knees - moist heat to quads, can WBAT (weight bearing as tolerated) on (R) leg. Follow up 4 weeks. . ." A physical therapy note, dated 11/8/10, indicated, "Wrote order for pt. (patient) to wear right knee immobilizer while in bed from 8PM - 2AM daily. Nursing was instructed on how to apply immobilizer correctly." On 11/10/10, documentation by physical therapy assistant indicated restorative nursing staff were instructed in the resident's care requirements, including stretching of the right knee to prevent contracture." A quarterly Minimum Data Set assessment, with assessment reference date of 12/31/10, indicated the following: Bed Mobility - Total dependence on 1 person Is this resident at risk of developing pressure ulcers? Yes Does the resident have one or more unhealed pressure ulcers at Stage 1 or higher? No No areas were identified, including unstageable areas. Nurses notes indicated the following: 1/25/11 (no time indicated) "Writer on weekly skin assess. . .one area on (R) (right) inner leg caused by leg brace, abrasion, one skin tear. . .Monitor and report that (R) knee to (illegible words). . .concerned use of leg brace, can it be D/C (discontinued)? causing more harm than good? Wound care team to look at. . ."	F 314	**Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings, the monitoring by the Director of Nursing/Designee of floating heels on hip fractures, immobilizers, and low air loss beds will be reviewed. Any patterns will be identified. If necessary, an action plan will be written by a committee appointed by the Administrator. The plan will be monitored weekly until resolution. **Completion on 02/27/2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 81 The next entry in nurses notes was dated 1/27/11 at 4:30 p.m. and indicated the wound care team was here to see the patient. On 1/27/11 at 3:00 p.m., the wound care specialist and Assistant Director of Nursing (ADON) were observed checking the wound. Upon entry to the room, the right leg was uncovered and the resident was observed with his right leg drawn up and the immobilizer in place, pressing into the back of the leg, causing an indentation on the leg. The wound care specialist took off the immobilizer and said it should only be on when the resident was out of bed; it has rubbed blisters and an area on back of leg 1.0 X 4, X 0.1 cm area, with yellow slough tissue noted at the center of the wound. The right heel pressure ulcer measured 0.5×0.6×0.1.cm. The wound care specialist indicated to discontinue the brace. After the wounds were examined, the leg was left resting on the mattress, with the wounds resting on the surface of the mattress. The ADON then covered the wound on the heel with gauze and reapplied the boot. At 3:23 p.m., LPN #1 returned to do the treatments to the wound. On 1/28/11 at 10:18 a.m. PTA #1 indicated the immobilizer was started with Resident #64 when he was on the Rehab unit. She indicated the immobilizer was initiated on 11/8/10 and was to be worn at night. She indicated she instructed nursing staff how to stretch leg and apply splint and to check for redness and no issues reported and the resident was discontinued from therapy on 1/12/11 and brace continued to be used at night and was to continue when transferred to	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 82 Skilled unit. She indicated the resident had really tight muscles. PTA #1 indicated on 1/14/11 nursing let her know of some redness on legs but didn't see any redness on either leg. She indicated she talked to staff to make sure they stretched his leg before applying because it would be uncomfortable and nursing staff reported the leg was still red this week so they decided they would have restorative put it on during the day when he had his nap. She indicated she talked to restorative about really stretching his leg so that the splint fit properly at that time. She further indicated they were going to discontinue the splint as of today (1/28) and let the area (pressure area) heal. On 1/18/11 at 3:41 p.m. the ADON indicated during interview she located an "interim" care plan for potential for pressure which included an approach for floating his heels but this was not brought forward to the care plan completed by the Minimum Data Set assessment staff. There was no way to know when the care plan, with the floating heels intervention was removed from the clinical record. The care plans for Activities of Daily Living and Osteoporosis, both dated 10/12/10, included an undated approach of "Rt (right) knee immobilizer on @ (at) 8P off @ 2A, but the approach did not include any instruction of the stretching the limb to ensure the immobilizer fit properly, as indicated by the physical therapy assistant. 2. Record review on 1/25/11 indicated Resident #108 was admitted from the hospital on 1/19/11 with unstageable pressure ulcers to both heels and a stage three pressure ulcer to the left sacral area. The physician's orders included a low air loss mattress. The Treatment Administration Record	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 83 indicated a Pressure Relieving Mattress was on the bed and was checked every shift. Interview with the resident on 1/26/11 indicated the mattress to his bed was comfortable, but the hose popped off at times and the mattress went flat. He indicated he put his call light on when it happened and staff came in and fixed it. It had happened a few times since he had gotten to the facility. Interview with CNA #1 on 1/27/11 at 1 p.m. indicated the resident told her the hose had popped off the mattress the previous day and she had told her charge nurse. Interview with LPN #3 indicated she had been oriented the previous week and she knew the mattress hose was popping off at that time, but if it was put back on, it reinflated. She said the company that supplied the beds probably needed notified, but did not know if they had been. Interview with ADON on 1/27/11 at 10:10 a.m. regarding the malfunctioning mattress indicated she had not been made aware of the problem, but would contact the company. The company who provided the mattress had a representative at the facility on 1/27/11 at 12:10 p.m. Interview at that time indicated there had been no previous notification of the malfunctioning mattress until 1/27/11. He had identified the problem as being the pump being slid over too far on the foot of the bed and the hose needed to go through the springs under the bed instead of over the bedframe. He reported that when staff reconnected the hose, the pump would have defaulted back to the previous	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 84 settings. 3.1-40(a)(1) 3.1-40(a)(2) 3.1-40(a)(3)	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff utilized planned assistive devices to prevent falls for a resident at risk for falls. This resulted in a resident sustaining a fall which required evaluation at a local emergency room. This affected 1 of 3 residents reviewed for falls in the sample of 8 residents with falls in the Stage 2 sample of 44. (Resident #56) Findings include: During interview of the nurse caring for Resident #56 on 1/25/11 at 2:18 p.m., she indicated the resident had sustained a fall in the past 30 days which resulted in a skin tear and a bump on the back of the head. The nurse indicated the resident was sent to the emergency room for evaluation when the fall occurred on 1/17/11. Resident #56's clinical record was reviewed on	F 323	**F323** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that the environment remains free of accident hazards as much as possible. Also, that residents receive supervision and assistive devices to prevent accidents. Resident #56 currently has a gait belt used for transfers and is not left unsupervised while in a position where assistance is required (such as sitting on bedside). **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who need assistive devices (such as gait belts) or supervision (such as while sitting on a bedside) will be listed. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 85 1/26/11. An Admission Fall Risk Assessment, dated 12/28/10, indicated a total score of 15 with a score of 10 or above = high risk. The Admission Fall Prevention Questionnaire, dated 12/18/10, indicated the resident had a history of falling in the last 30 days. According to the care plan, "At risk for falls related to Hx (history) of falls prior to admission) printed 1/5/11, the resident experienced a fall on 12/29/10 "assisted." The care plan was unchanged following this fall and a second fall occurred on 1/17/11, "assisted." The goal indicated, "Resident will not substain (sic) a significant injury from falls, thru next review." Approaches included, but were not limited to, "Assist of 1-2 for transfers, with gait belt." According to the Minimum Data Set (MDS) assessment, with assessment reference date of 12/29/10, the resident's functional status was as follows: Transfer - required assist of 1 person Walk in room & corridor - did not occur Balance during transitions and walking - Moving from seated to standing position - Not steady, only able to stabilize with human assistance Surface-to-surface transfer (transfer between bed and chair or wheelchair) - Not steady, only able to stabilize with human assistance Any Falls Since Admission or Prior Assessment - Yes Nurses notes indicated the following: 1/17/11 7:30 a.m. "Aide was in resident's room at app (approximately) 6:45 A (a.m.) attempting to get resident's weight when aide assisted resident to step back and set on bed. Resident stepped	F 323	DON/Designee will monitor 10 residents daily 3 days weekly on various shifts who require gait belt use and who need supervision sitting alone to be sure proper care is being delivered. Any concerns will be addressed immediately. This monitoring will continue until 4 consecutive weeks of zero negative findings are realized. Then weekly random monitoring will occur. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At an all staff inservice on 02/15/11, the importance and necessity of using a gait belt or other assistive device to help a resident be safely cared for when indicated was reviewed. Also, supervising residents who are not able to safely sit (or stand) independently was discussed. Any staff who fail to comply with these requirements will be disciplined up to and including termination. Element #4 ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be***	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 86 sideways instead and fell to the floor, writer was (illegible word) walking into room as saw resident fall backwards and hit the floor butt first. Later her head fell back and hit the wall, resident remained concous (sic). . .Resident has 4 cm (centimeter) wound and some puncture wounds on upper (R) (right) arm and (R) hip [with] serosanguinous drainage. . ." On 1/24/11 at 3:30 p.m., during discussion of Resident #56's fall with the Director of Nursing (DON), she indicated the CNA failed to use a gait belt during the resident's fall on 1/17/11 and she was terminated. Documentation indicated "(Name of CNA) was transferring resident (Name of Resident #56) in the morning she was not using a gait belt as per our policy. Resident (#56) fell hitting her head, resident was then sent to. . ."	F 323	***put into place; and completion date*** At the monthly Quality Assurance meetings the monitoring of the DON/Designee related to safety device use and proper supervision will be reviewed. Any concerns will have been addressed immediately upon discovery. **Completion date 02/27/2011.**	
F 329 SS=D	3.1-45(a)(2) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 87 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 9 residents reviewed for psychoactive drug use in a Stage 2 sample of 44 received adequate monitoring for their use. (Resident #5) Findings include: During observation on 1/26/11 at 8:35 a.m., Resident #5 sat quietly feeding herself breakfast. Interview with the resident on 1/27/11 at 9:13 a.m., indicated she could state her name, was aware of her surroundings and answered questions appropriately. The 8/20/10 and 10/11/10 Minimum Data Set [MDS] admission assessments indicated the resident received Klonopin and Xanax for depression, anxiety, increased confusion and wanting to leave the facility. The November 2010 Medication Administration Record [MAR] indicated Klonopin .25 mg was given BID until increased to .5 mg on 11/24. The MAR indicated Xanax .5 mg was given for anxiety and agitation on 11/11, 11/15, 11/18, 11/22, and 11/30/10.	F 329	**F329** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that residents are free from administration of unnecessary drugs. Resident #5 has been reassessed and has had their record reviewed including care plan, behavior monitoring sheets, and a medication review by nursing administration, social services director, activity director, dietary director, pharmacy consultant and physician. Resident #5's care is given with the least amount of psychoactive medications as possible given only after attempted non-medicine interventions which are documented. Also, dose reductions should be attempted unless contraindicated. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** See Response To Element #2 – F250	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 88 The Behavior/Intervention Monthly Flow Record for November 2010 indicated the behaviors being monitored were resisting care and refusing to wear hearing aides. The record indicated the resident had only one day in November, 11/8/10, she exhibited any of the behaviors being monitored. Review of November 2010 nurses notes failed to indicate any display of behaviors on 11/15, 11/18, 11/22 or 11/30 when the Xanax was given. The 11/11 nurses notes indicated at 4 a.m. the resident was getting out of bed, removing alarm, and had confused conversation. The December 2010 MAR indicated Xanax was given: 12/1 at 1 AM and 9 AM for increased anxiety and exit seeking 12/3 for fearful and anxious 12/14 increased anxiety 12/27 increased anxiety written on back of MAR 12/29 increased anxiety tearful, exit seeking written on back of MAR The Behavior/Intervention Monthly Flow Record for December 2010 indicated the behaviors were the same as for November and the resident had only exhibited these behaviors on 12/1/10 and 12/14/10. Nurses Notes for December 2010 indicated the resident only displayed these behaviors on 12/3. Klonopin .5 mg bid was given the month of December 2010. The care plan for psychoactive drugs was, "at risk	F 329	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** See Response To Element #3- F250 **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** See Response To Element #4- F250 **COMPLETION DATE:02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 89 for adverse side effect from the psych use." The care plan was dated 8/25/10 and current through 2/23/11. at risk for increased anxiety episodes of saying help me, i want to go home. none are easily altered The goal for the problem was, "Anxiety will be controlled through use of medication." Interventions included: observe for factors that trigger anxiety, record in behavioral log, observe for nonverbal signs of anxiety fidgeting, increased restlessness; provide diversional conversation; record in behavioral log; observe for SE; and added to cp on 11/13/10 resisting/refusing (refusing to wear hearing aides) A MD progress note, dated, 12/30/10, "Anxious c [with] improved control c (increase) in Klonopin dose. No GDR [gradual dose reduction]. It would be harmful to pt [patient]. Pharm [pharmacist] rec re [recommendations regarding] GDR Klonopin but dose recently increased due to break through anxiety." Review of the current MAR 1/2011, indicated Xanax given PRN: 1/1 at 8 a.m., tearful 1/12 at 7 a.m., tearful wanting to go home 1/19 8 a.m. 1/21 8 a.m. tearful, husband coming to get her The Behavior/Intervention Monthly Flow Record for January 2011 indicated, the behaviors resists care, refuses to wear hearing aide and anxiety - yelling to go home were monitored. Documentation that 1 on 1 and activity were the interventions tried on 1/12, 1/ 19 and 1/21 on the day shift.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 90 Interview with LPN #1 on 1/27/11 at 10:20 a.m. indicated the behavior sheet for November 2010 showed on Nov 8, 2010 the resident was marked as having continuous behaviors for the night shift, but no other behaviors were marked. Nurses notes was where additional charting on behavior incidences would be found. LPN #1 indicated the resident needed the psychoactive drugs because she became very tearful, exit seeking, depressed and during these times, she was not easily redirected.	F 329		
F 353 SS=E	3.1-48(a)(3) 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	**F353** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that there is sufficient nursing staff 24 hours per care plans. Currently, all residents on the Special Care Unit or other dining rooms have adequate staff to help cue, or feed them, or assist them to eat safely and timely. This includes Residents # 87, #37, #14, #5, #68, #41, #21, #28, #64, #17, and #73 **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** See Response To Element #2- F241	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 91 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide nursing staff in sufficient numbers to ensure residents were assisted with eating, cued as needed to eat at their highest level of functioning, and supervised during the meals in 1 of 4 dining rooms for 2 of 2 meal observations. This affected 11 identified residents and 7 additional unidentified residents observed during 2 of 2 lunch meals in 2 of 4 dining areas and had the potential to affect all 15 residents residing on the unit. (Residents #87, #37, #14, #5, #68, #41, #21, #28, #64, #17, #73) Findings include: 1. During observation of the Special Care Unit on 1/24/11 at 12:05 p.m., lunch was served on trays and left on trays in front of the residents. LPN #2 sat by Resident #41 and encouraged and assisted him to eat. She encouraged other residents to eat from her location at Resident #41's side. This required her to yell across the room to the other residents. During this time, Resident #87 had started to eat but then placed her meat and potatoes in her dessert and no staff intervened. One resident came in and sat at the table with Resident #41. She was eating with her knife and no staff intervened. At 12:17 p.m., five trays remained unserved. LPN #1 indicated only one resident ate in their room and the remaining four residents needed reminded to come to the dining room. At 12:34 p.m., the final tray was served when Resident #37 was brought to the dining room.	F 353	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** See Response To Element #3- F241 **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** See Response To Element #4- F241 **COMPLETION DATE:02/27/11**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 92 2. The following was noted during lunch observation on the Special Care Unit on 1/27/11: At 12:29 p.m., a resident was taken to a physician's appointment by ambulance and had not been served lunch before leaving. LPN #2 reported she would only be gone a few minutes. Trays arrived at 12:29 p.m. Resident #37 was served and had food prepared, but did not start eating. Resident #14 , at the same table, sat in front of her food, not eating. Resident #14's meat, a piece of steak, was not cut for her. Resident #73 was served her meal by staff; staff left and came back to feed her when all the trays had been passed at 12:40 p.m. During this time, the resident was trying to eat her cornbread with her hands. She was left alone and she began eating pinto beans with her hands. Resident #68 had ground meat on her tray, and also a green lettuce salad with a large chunk of cauliflower. There were magazines laying beside the resident's meal tray. The resident kept going from meal to magazine, without staff intervention/direction. At 12:46 p.m., LPN #2 sat down between Residents #37 and #87. Resident #14 continued to not eat, with no staff encouragement at 12:51 p.m. At 12:53 p.m., Resident #87 put her dinner plate in the middle of the table, after eating cornbread and a few bites of greens; no dressing was put on the salad.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 93 Resident #5 put the dinner plate off to the side of her after consuming a few bites of greens and cornbread; she put the salad on the tray, along with pinto beans, but was not eating and was not encouraged by staff to eat. There was no staff encouragement for Resident #87 to eat. She took a health shake and attempted to put a fork into the carton, picked up a straw and put it into the health shake and drank some of it. Staff encouraged her to eat her cake, but did not put the cake in front of her or assist her. One resident sat at a table by herself, had no dressing on her salad, and wasn't encouraged to eat. At 12:55 p.m., Resident #14, who had been served first, sat at the table and was not encouraged to eat. Resident #5 was not encouraged to eat, and moved her salad from her plate to the table. At 1:15 p.m., Resident #68 was stuffing an advertisement, from the magazines beside her, in a cup and was still not eating. Resident #37 sat next to her, was fed by the nurse, but not encouraged to eat. Resident #87 took 2 bites of cake and then fell asleep. At 1:16 p.m., Resident #68 was asked if she was finished; she was offered other things and refused; offered another "Boost" and refused, stating she was not very hungry. At 1:16 p.m., Resident #5 dumped beans from	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 94 the bowl onto her plate, spilling them onto the table and started stacking dishes. The resident who had gone for the physician's appointment at the beginning of the meal had not returned at the conclusion of the observation period. 3. During the first dining observation of lunch on 1/25/11 at 12:00 p.m. in the main dining room, the following was observed: One resident at a table was served food; 10 minutes later the other three residents at this same table were still waiting for food. Resident #21 had difficulty lifting her ice water and spilled half of the ice in her drink onto the table. It was 10 minutes before staff noticed it to assist the resident. Resident #28 was in a recumbent wheelchair and unable to reach her food on the table. The resident was wheeled back to the room, without eating any food. 4. During the second dining observation of the main dining room on 1/28/11 at 12:15 p.m., the following was observed: Fifty percent of the residents sitting at the same table were served at different times, sometimes up to 10 minutes apart. Resident #21 did not receive any staff assistance to cut her meat or open her milk. The resident yelled, "nurse come help me, no one cut my meat or opened my milk."	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 95 Resident #28 was in a recumbent wheelchair and did not reach the table. A staff member cut her meat while standing over her, then left the resident. The resident could not reach the items on her tray and did not feed herself. Ten minutes later, a staff member came back to her table and pushed her wheelchair up closer to the table. The resident tried to reach her food, but was still unable to reach it. Resident #64 was not assisted or fed and all of his meal was untouched. Resident #17 ate 3/4 of her cornbread and the remainder of the food was left uneaten. No staff members were observed to assist the resident. 3.1-17(a)	F 353	**F356** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Currently, Nursing Staffing information is posted in the foyer at the beginning of each shift reflecting all required information per regulation. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. The administrator or designee will be responsible for seeing that this posting is put up timely and accurately daily at the start of the shifts. A log will be kept of the time posted by the administrator or designee. The log will be monitored weekly for timeliness and accuracy of posting.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 96 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the required information regarding nurse staffing was posted on a daily basis, at the beginning of each shift. This had the potential to affect all 78 residents residing in the facility. Findings include: 1. During the initial tour of the facility on 1/24/11 at 9:30 a.m., the nurse staffing posting listed in the foyer was dated 1/21/11. During the afternoon on 1/24/11, the posting had been changed to reflect the 1/24/11 staffing. 2. On 1/27/11 at 7:45 a.m., nurse staffing posting in the foyer area was dated 1/26/11. On 1/27/11 at 8:00 a.m., the posting remained dated 1/26/11 and was not changed until an observation on 1/27/11 at 8:40 a.m. 3. On 1/28/11 at 9:14 a.m., there was no staff posting for the day on designated board in the foyer.	F 356	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At all staff inservice held on 02/15/11, the necessity of the posting of hours was reviewed. Those who might be interested in these numbers were discussed. Staff was reminded where the posting is placed. Those responsible for posting were reminded of their role. Failure to comply with posting will result in disciplinary action. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place;*** *and completion date* At the monthly Quality Assurance meetings the "log" for nursing hours "postings" will be reviewed. Any pattern will be identified. The Administrator will monitor weekly. **Completion date 02/27/2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 97 3.1-13(a)	F 356		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received food that was palatable. This affected 1 of 16 residents interviewed during the Stage 1 survey. In addition, this affected 1 of 1 resident council president and was brought up in 3 of 11 resident council meeting minutes reviewed for the past 11 months. (Resident #56, Resident #114 (Resident Council President)) Findings include: 1. Resident #56 was interviewed on 1/24/11 at 3:10 p.m.. She indicated she receives food that is too salty from the dietary department. The resident indicated she has to watch her salt intake due to problems with edema. 2. Resident #114 was interviewed on 1/26/11 at 10:30 a.m. She indicated the food is salty at times and she had recently had vegetables that were too salty. 3. The resident council minutes were reviewed on 1/27/11. The following was noted from the minutes:	F 364	**F364** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that food served is nutritious, attractive, palatable and attractive. Resident #56 and #114 receive food with no added salt. The dietary department does not order salt for seasoning nor is it used. The dietary department orders frozen meats and vegetables to avoid salt in canned foods. The only two products ordered "canned" are chicken noodle soup and tomato soup. The facility changed its gravy mix to avoid salt. The Resident Council Meeting minutes mentioned food being salty in February 2010. This is several months ago. All of these practices were in place during the time and prior to the survey. Meat served is tender as cooked. The meal in question was a "Resident Choice" meal. It was voted on by the residents to be served. It was voted on twice in the past 2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 98 2/17/10 - "Concern from last meeting" - "5. food too salty." - "5. not resolved." Department Areas of Concern: "Dietary: Food is still tasting to (sic) salty. . ." 3/24/10 - Department Areas of Concern: "Dietary: meat is tough. . ." 4/21/10 - Department Areas of Concern: "Dietary: Food to (sic) salty. . ." 4. After the second dining observation of lunch on 1/26/11 at 1:30 p.m., the facility provided a test tray of a regular diet. Each item was tasted and the steak was tough in texture and difficult to chew; the spinach and cornbread were salty to taste, and the cake was very dry in texture.	F 364	**Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** See Response To Element #2- F241 **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** See Response to Element #3- F241 **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** See Response to Element #4- F241 **COMPLETION DATE:02/27/11**	
F 371 SS=F	3.1-21(a)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored in a sanitary condition to prevent possible cross contamination and potential food borne illness in 1 of 1 freezer	F 371	**F371** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that food is stored and prepared in sanitary conditions. Frozen meat is not stored above frozen biscuits or frozen vegetables	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 99 and 1 of 1 refrigerator in the facility kitchen. This had the potential to affect 74 of 78 residents receiving meals from the kitchen. In addition, the facility failed to ensure foods were stored properly in 1 of 3 nutrition pantries and failed to ensure staff followed sanitary procedures when serving food. Findings include: 1. On 1/24/2011 at 9:30 am during the initial tour of the kitchen, the freezer was observed to have frozen meat stored above frozen vegetables. A 5 pound (lb) plastic container of yogurt was noted in the refrigerator with print on the bottom of container which indicated, "use by 1/ 10/11." There were two additional 5 lb. containers of yogurt with print on the bottom of the container "use by 1/15/11." Interview with the Dietary Manager on 1/25/11 at 10 a.m., indicated she had contacted the facility food service provider and the food service provider indicated the "used by date meant it should be discarded after the date on the container." 2. On 1/27/2011 at 10:10 am, during an observation of the freezer, there was frozen meat including fish sandwiches stored above frozen vegetables. On the opposite side of the freezer, there were frozen pork patties stored above frozen biscuits. 3. During observation of the noon meal on 1/24/11 at 12:00 p.m., two staff members were observed to touch the resident's bread with bare hands to butter it. Two staff were observed to touch the resident's plastic eating utensils on the	F 371	in the freezer. Yogurt nor any food is used past "use by" date. Staff don't touch bread with bare hands to butter it. Staff do not touch the utensils except on the portion that would not go into the resident's mouth. Further, all food is the refrigerator that is opened, is dated. Snack trays are clean. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who receive food from the dietary department have the potential to be affected by this finding. At least 3 days weekly, the Dietary Manager will monitor the following: Note (DON/Designee will monitor C and D) a. Frozen meat not stored above other food in freezer b. Food is not used beyond "use by" date c. Staff don't touch bread with bare hands d. Staff don't touch utensils (part that goes in mouth) e. Opened food in refrigerators is dated f. Snack trays are clean	

F 371 Continued
This monitoring will continue until 4 consecutive weeks of zero negative findings is realized. After that, random weekly monitoring will occur.

Element #3
What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
At the all staff inservice held on 02/15/11, the following was covered:

a. Food contamination from meat drippings
b. "Use by" dates on food- Can't go past
c. Touching bread with bare hands- Contamination
d. Touching utensils improperly- Contamination
e. Why we must "date" opened food in refrigerator
f. Clean snack trays- Contamination

Any Staff who fails to comply with the points of this inservice will be further educated and/or progressively disciplined as appropriate.

Element #4
How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date
At the monthly Quality Assurance meetings the monitoring of the Dietary Manger will be reviewed. Any concerns would have been corrected as found.
Completion date 02/27/2011.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 100 ends which touched the residents' mouths. 4. The Nutrition Pantry on the Skilled Unit was observed on 1/27/11. There were two open packages of turkey and ham lunch meat, without date of opening. There were two 1/2 gallon boxes of ice cream and 1 gallon container of ice cream which had been partially melted and refrozen. There were no dates of opening on the containers. There was a tray of bananas and packaged snacks on the top of the refrigerator. The tray was soiled with dirt/debris in and under the snacks. 3.1-21(i)(3)	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F 431** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that drugs are labeled and stored and disposed of properly. Currently, all medication is properly stored and not laying loose on any cart or countertop. All medications are in a labeled container. Resident #91 and #114 both have their meds administered and destroyed per policy. Only the nurse has access to the med room. If the floor is mopped, the nurse must be present. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who are on the mentioned units have the potential to be affected by this finding. The DON/Designee will monitor the following at least 3 days weekly:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 101 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure drugs were properly labeled and destroyed timely. The facility also failed to ensure only authorized personnel had access to medications. This was noted in 2 of 3 medication rooms observed during the survey. This affected 2 residents residing on the Skilled Unit and had the potential to affect the 67 residents residing on these two units. (Resident #91, #114) Findings include: 1. During observation of the medication room on the Skilled unit on 1/28/11 at 9:57 a.m., three Biscadoyl suppositories were laying loose, in no container, on the countertop, without identification information. 2. During observation of the medication room on the Skilled unit on 1/28/11 at 9:57 a.m., a partially filled bottle of Mary's Magic Potion remained on the counter for Resident #91. The bottle was dated 1/12/11 for administration until 1/14/11 and then re-evaluate; there was no indication when	F 431	a. Observe medication rooms for properly stored medications b. Medication destroyed timely (if dc'd) c. Only authorized staff (nurses, pharmacist, and physician) have access to the medication room d. Medications properly locked in carts/refrigerator as appropriate These monitoring will continue until 4 consecutive weeks of zero negative findings occur. Then random weekly checks will be made. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff inservice held on 02/15/11, the following was covered: a. Medications- proper storage/labels/destruction b. Authorized staff only in medication rooms Any staff who fail to comply with the points of the inservice will be further educated and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 102 the medication would be destroyed. A partial bottle of Robitussin syrup was observed in the medication room for Resident #114. The bottle was dated 12/17/10 and was to be administered for 14 days. 3. On 1/28/11 at 10:07 a.m. on the Secured unit LPN #2 was observed at the nurses' station, located near the front of the hall/unit. Upon request to view the medication room, LPN #2 walked the length of the hallway, to the back of the unit, where she said the housekeeper was mopping the floor. Upon arrival at the medication room, the door was propped open and the housekeeper was mopping the floor, without the nurse being present. The medication refrigerator was unlocked in the room. 3.1-25(j) 3.1-25(m) 3.1-25(o)	F 431	progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings, the monitoring of medication rooms will be discussed. Any concerns will have been corrected immediately upon discovery. **Completion date 02/27/2011.**	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	**F441** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that an Infection Control Program is in place to provide a safe sanitary environment to help prevent the spread of infection. Currently, all staff wash their hands after removing gloves. Proper solution is used to clean glucometers between residents. This is based on the most recent newsletter from the Indiana State Board of Health.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 103 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff washed their hands following resident care, failed to ensure glucometers were sanitized as required between residents for 4 of 4 residents observed during glucometer checks, and failed to ensure infection control procedures were followed during treatments. This was observed on 3 of 3 units. Findings include: 1. During an observation on 1/27/11 at 6:20 a.m., CNA #1 washed her hands, donned gloves, and assisted Resident #56 back to bed. After providing assistance to the resident, the CNA	F 441	Open wounds are not subjected to unclean surfaces. Gloves are removed and hands washed afterwards. Nurses do not touch treatment carts with contaminated hands/gloves. Gloves are not used for more than one task or more than one resident. Scissors are not kept in unclean areas before use. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents who have dressing changes or glucometer blood sugar checks have the potential to be affected by this finding. Going forward the DON/Designee will monitor 10 glucometer checks weekly (various nurses and shifts) to be certain proper technique is used. Any concerns will be corrected immediately. Also, 10 dressing changes weekly to see that all proper technique include glove donning and hand washing and clean scissor use are practiced. Any concerns will be corrected immediately. This monitoring will continue until 4 consecutive weeks of zero negative findings is realized.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 104 removed her gloves, assisted the resident with water, and left the room, without washing her hands. The CNA proceeded down the hall, touching the linen cart and barrels in the hallway before assisting another resident 2. During observation on 1/27/11 at 6:50 a.m., RN #1 performed a glucometer check (blood sugar test) for Resident #83. Following the test, the nurse wiped the glucometer machine with alcohol wipes (70% alcohol) prior to use on the next resident. RN #1 indicated the policy/procedure is to wipe with alcohol for 1 minute between resident use. The policy for cleaning glucometers was provided for review by the Administrator on 1/27/11 at 7:10 p.m. The policy indicated the meter would be cleaned after each resident use and as needed. The policy indicated, "Clean outside of meter case, using lint free damp cloth." A note on the policy indicated, "If dried blood or debris is noted on the meter, it may be cleaned with a dampened cloth with warm soapy water or isopropyl alcohol or 10% diluted bleach." During observation on the Secured unit, glucometers were cleaned with Super Sani-cloth sanitizers. 3. During observation of the treatment to Resident #64's pressure ulcer, the wounds were uncovered and allowed to rest on the mattress cover. Before leaving the room, the wound on the heel was covered with a dry gauze, after it had been allowed to rest on the bed, uncovered. The wound on the back of the leg was not covered prior to the wound specialist and the Assistant Director of Nursing exited the room. LPN #1 was then observed to enter the room to complete the treatments to the areas. The nurse took the	F 441	Afterwards, random weekly monitoring will be done. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff inservice held on 02/15/11, the following was covered: a. Hand washing b. Glove donning/hand washing upon removal c. Clean dressing technique d. Glucometer cleaning e. Cross-contamination with gloves f. Scissors/Clean Any staff who fails to comply with their role at performing the points of the inservice will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings the monitoring related to Infection Control done by the DON/Designee will be reviewed. Any patterns will be discussed;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 105 entire treatment cart into the room. Following the treatment to the heel wound, LPN #1 opened various drawers on the treatment cart, while still wearing the soiled gloves worn during the treatment to the wound. 4. Observation on 1/27/11 at 11:45 am, LPN #1 used gloves as she used Super Sani-cloth to clean a glucometer to use for a resident. She wore the same gloves to prick the resident's finger to obtain a blood sample, and hold a paper towel on the resident's finger until the bleeding stopped. LPN #1 took the gloves off and held in her hands along with the paper towel she had used to hold the pricked finger, as she wheeled the resident back to the dining room. She cleaned the glucometer and then went to a resident who was on the floor without washing her hands. The CNA had told her the resident was okay as he had just gone to his knees. 5. Observation on 1/27/11 at 2:44 p.m. of LPN #3 completing the pressure ulcer treatment for Resident #108 indicated the following: The nurse washed her hands before donning gloves to paint the resident's heels. The nurse removed her gloves and left the room twice to obtain supplies, without washing her hands. She used a pair of scissors that was on the over bed table to cut the resident's dressings to the correct size. One of the dressings was the Purocol which laid directly on the wound. Following cutting the dressing, she laid the scissors back on the over the bed table. At the completion of the treatment, she placed the scissors into her pocket. Interview with LPN #3 at the completion of the treatment indicated the scissors were her personal scissors that she kept in her pocket, and	F 441	however, any concerns will have been addressed immediately as noted during the monitorings. Any patterns will be identified and any further education will be given "on the spot" as needed. **Completion date 02/27/2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 106 she had cleansed them with a bleach wipe prior to entering the room. 6. Observation on 1/27/11 at 11:45 am, LPN #1 used gloves as she used Super Sani-cloth to clean a glucometer to use for a resident on the special care unit. She wore the same gloves to prick the resident's finger to obtain a blood sample, and hold a paper towel on the resident's finger until the bleeding stopped. LPN #1 took the gloves off and held in them in her hands along with the paper towel she had used to hold the pricked finger, as she wheeled the resident back to the dining room. She cleaned the glucometer and then went to a resident who was on the floor without washing her hands. The CNA had told her the resident was okay as he had just gone to his knees. 7. The Assistant Director of Nursing (ADON) was interviewed on 1/28/11 at 9:30 a.m. concerning the infection control program. The Director of Nursing was actually the nurse in charge of the program, but she was unavailable. The ADON indicated the staff logged the infections and the antibiotics used to treat the infections. A report was then prepared and presented each month at the quality assurance meeting. The facility had a manual of infection control policies and procedures. The ADON indicated staff tracked to identify any patterns of infection or breaks in procedures. She indicated she was doing an audit for handwashing. She randomly chose staff twice a week to observe while the staff were doing care. She had no negative findings from her audit. She also indicated the two residents with Clostridium difficile infections in the facility had come from hospitals in the area and were not nosocomial. No pattern with had been identified with urinary tract infections and particular	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 107 organisms. Inservices for infection control and handwashing were completed with new hires and at least one time each year with all staff. The policy and procedure for handwashing was presented by the Assistant Director of Nursing on 1/28/11 at 10:30 a.m. It indicated the following: "Hand washing is the single most important measure for preventing the spread of infection. The employee should wash his/her hands routinely after each direct Resident contact (as indicated by accepted professional practice) and after handling contaminated articles." "Procedure: If you are wearing a watch, push your watch well above your wrist. Turn on the faucet using a clean paper towel and adjust it to the desired temperature before you begin washing. It is best to use warm water when washing your hands. Avoid touching the sink with your uniform in that the sink is considered dirty. Angle arms down holding hands lower than elbows (so that the water runs from the cleanest to the dirtiest area) and wet your hands and wrists thoroughly. Put soap in hands. If you are using bar soap rinse it before and after you use it and drop it into the soap container. Lather all area of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, your palms, and around your finger nails. Continue this scrubbing action for twenty seconds. Clean you nails by rubbing them in the palm of your other hand. Rinse thoroughly by holding your hands downward under the faucet so that the water runs from wrists to fingertips. Be sure to remove all soap to avoid chapping, irritation, or rashes. Pat dry your wrists and hands with paper towels. Turn off faucet with paper towel and discard paper towel. Remember,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 108 the handle is considered contaminated." "The following are instances when hand washing must be done: Coming on duty; Hands are obviously soiled; Before and after caring for each Resident; After using the bathroom; After blowing or wiping nose; After handling used dressings, used sputum containers, urine, bedpans or urinals, catheters, soiled linens or assisting Resident in/to bathroom; Before and after eating; Upon leaving an isolation area or handling articles from any isolation area; After contact with Resident blood or body fluids; Before performing any invasive procedures on a Resident; After removing gloves; Upon completion of duty, before leaving the facility." The facility policy for "Gloves, Non-sterile" was presented by the ADON on 1/28/11 at 9:55 a.m. as the most recent policy. It included: "Disposable clean gloves are worn to protect the hands when health care personnel are likely to be exposed to blood or body fluid. Health care personnel shall wear gloves when there is anticipated hand contact with blood or other potentially infectious material." "Guidelines: Non-sterile disposable gloves are to be worn during any procedure where exposure to blood or body fluids is anticipated. Disposable gloves shall be replaced when contaminated, torn, punctured, or when their function as a barrier has been compromised. Disposable gloves are not to be washed. Disposable gloves shall be utilized for single resident use only....." The facility policy for "Dressing - Clean Technique" was presented by the Assistant Director of Nursing on 1/28/11 at 9:55 a.m. The	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 109 policy indicated the following: "A clean dressing technique is used to provide an appropriate and safe environment conducive to wound healing. All dressings are performed by licensed personnel according to physician order using clean technique, unless another technique is specified by the physician." "Procedure: Verify physician order and identify Resident. Explain procedure to Resident and provide privacy. Wash hands. Put on gloves. Removed soiled dressing and discard into designated waste receptacle. Remove gloves, wash hands, and put on a pair of clean gloves. Cleanse wound with solution as specified by physician. Apply dressing as specified by physician, touching only the outer part of dressing. Remove gloves. Apply tape sparingly, if necessary. Wash hands. Document any pertinent observations in the medical record." 3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(b)(3)	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was clean and sanitary for employees and the public in that 1 of 2 visitor's restrooms was soiled, the laundry was	F 465	**F465** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that the environment is safe, functional and sanitary. Currently, the visitors women's restroom is clean and sanitary with no soap running down the wall to the floor. The Rehab Medication Room has a clean floor and walls. In the Laundry Room: Holes behind washers are repaired. The hole above soaking sink is repaired. The walls are finished and painted. Windows are clean and have panes replaced. Ceiling in dryer vent area is fixed. Water damage in ceiling is fixed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 110 soiled, and 1 of 3 medication rooms was heavily soiled. Findings include: 1. On all days of the survey, the visitors women's restroom was observed with liquid soap soiling down the wall under the soap dispenser and a heavy build-up of liquid soap on the floor under the soap dispenser. 2. On 1/28/11 at 10:28 a.m., the Rehab Medication Room was observed with a heavy accumulation of dirt/debris behind the door to the room. 3. The laundry was contained in a separate building located behind the facility. During observation of the area on 1/28/11, there were holes in the wall behind the washers. There was a hole in the wall above the soaking sink. The walls in the laundry had areas of missing paint and/or unfinished wallboard. There was a heavy accumulation of dust and cobwebs in the windows near the washers. One window glass was missing with a plywood insert in its place and the bare wood had been wet, with water staining noted on the base of the board. The ceiling in the dryer vent area was missing sections of the wallboard and additional wallboard in the ceiling had water damage areas noted. Laundry Employee #1 indicated at this time they tried to clean the areas, but it was hard to keep it that way. 4. The Skilled Unit Nutrition Pantry was observed on 1/28/11. The refrigerator door shelves were soiled with dried spills. The top shelf of the refrigerator was soiled with dried sticky	F 465	Skilled Unit Nutrition Pantry: Refrigerator shelves are clean. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by this finding. The Administrator and/or the Corporate Environmental Director (Housekeeping, Laundry, Maintenance) will make weekly environmental rounds to see that the environment is clean and sanitary. All areas listed on this finding will be part of the rounds. The Administrator will work with the maintenance department weekly to resolve any issues. Action plans will be written to track repairs. **Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff inservice held on 02/15/11, the necessity of having a clean, safe comfortable environment was discussed. Staff was instructed how to write a maintenance request for any concern they observe. Staff	

F 465 Continued
will all be expected to perform their designated roles to see that the facility environment remains clean and safe and comfortable. Any staff who fail to comply with the points of this inservice will be further educated and/or progressively disciplined as necessary.
Element #4
How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date
At the monthly Quality Assurance meetings the results of the environmental rounds and action plans will be reviewed. The Administrator will make any new needed recommendations and monitor them weekly to completion.
Completion date 02/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 111 substances. 3.1-19(f)	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish an effective quality assurance program which would have identified and addressed concerns discovered during the survey process. This potentially affected all 78 residents	F 520	**F520** **Element #1** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** It is the policy of this facility to see that the Quality Assurance Program is utilized to identify concerns in the facility. The Quality Assurance Program has been updated to include more specific questions/ observations to identify concerns. **Element #2** ***How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All the residents have the potential to be affected by this finding. Going forward, the Quality Assurance Program will include monitoring tools and interview tools taken directly from the Q.I.S materials manual. The tools will be rotating and will cover all areas on a schedule. The department heads will be responsible to gather information pertinent to their department's concerns and responsibilities monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 112 living in the facility. Findings include: The Administrator was identified as the contact person for quality assurance concerns during the entrance conference meeting on 1/24/11 at 10:30 a.m. The Administrator was interviewed on 1/28/11 at 10:30 a.m. concerning the quality assurance program. He indicated the facility had addressed gouges in the walls of the residents through the quality assurance program. He indicated there had three possible solutions identified to date and since the first two protections had not been effective, the facility was now trying the third as a possible solution. He also indicated the facility had not been aware of the concerns with infection control, but had an on-going program to prevent any concerns. He indicated the infection control program had not identified any concerns through the observation audits that had been performed. He indicated the activity director was new in her position and so was not aware of the management of the resident council. He also indicated the activity director would be attending the state class for activity directors and would be better able to meet resident rights needs after completing the course. He indicated no concerns had been identified in activities or resident rights through the quality assurance committee. He indicated the quality assurance program had already dealt with the salty food issue of food quality. He indicated the staff had purchased low	F 520	**Element #3** ***What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;*** At the all staff inservice held on 02/15/11, the importance of ongoing monitoring and interviewing in all resident care areas in order to identify concerns which when addressed would result in better quality of care for the residents was reviewed. Each staff member is expected to perform their role in providing quality care to the residents. Any staff who fails to comply will be further educated and/or progressively disciplined as necessary. **Element #4** ***How the corrective actions will be monitored to ensure the deficient practice will not recur; ie what quality assurance program will be put into place; and completion date*** At the monthly Quality Assurance meetings, the results of the monitoring tools by the department heads will be reviewed. Any concerns will be identified. Action plans will be written as indicated by committees appointed by the Administrator. These plans will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 EAST 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 113 sodium gravies and had pursued a program of "no added salt" cooking. He indicated he was not aware of any food concerns since May 2010. He also indicated the quality assurance program had an on-going program which included pressure sores, falls, restraints, and infection control. He indicated these audits had produced no negative findings since the last survey. He presented a "Monitoring Tool For Resident Abuse." The completed tools were dated for 2006 and 2007. All of the residents interviewed on the tools indicated they were happy living in the facility and felt safe. No other information was presented prior to the final exit from the facility on 1/28/11 at 6:00 p.m. 3.1-52(b)(2)	F 520	monitored weekly by the Administrator until resolution. **Completion date 02/27/2011**	

#149 #1

ADDENDUM TO POC
Survey Event ID: L5S211 Survey Date: January 28, 2011

F 160: Element #3: "Any monies that are not returned timely after the death of a resident will be explained." Please include whether the resident's representative will be included in the explanation.

F 160: Any monies that are not returned timely after the death of a resident will be explained fully to the resident's representative. Every effort will be made to get the refund completed timely and correctly.

F 225 and F 226: Please include ongoing education of staff regarding abuse identification and prohibition.

F 225 and F 226: The facility conducts all staff in-services every two weeks on paydays. The abuse identification and prohibition policy are covered in general every in-service. This policy is covered in-depth at quarterly all staff in-services.

F 241: If an action plan is necessary, who will be responsible for monitoring the plan?

F 241: Should an action plan be written by a committee appointed by the Administrator, the plan will be monitored weekly by the Administrator until resolution is achived.

addendum approved 03-09-11

F 244: At what point will the resident be consulted regarding their satisfaction with the resolution?

F 244: Immediately following any necessary research and/or investigation into a concern and how best the facility can resolve it, the resident will be educated as to the findings and the proposed resolution. Their satisfaction will be sought. If there is further concern with the issue, move effort will be made until the complaining party is satisfied to the greatest degree possible. This will be documented.

F 250: How often will all residents on psychoactive drugs be evaluated for dosage reduction?

F 250: Residents on psychoactive meds will be evaluated for possible dose reduction at least quarterly.

2

#149

Page Two Addendum to Survey L5S211 January 28, 2011

F 282: Will nursing notes or other document/tool be used for pain management assessments?

F 282: A pain assessment tool will be used to help in the assessment of pain. Pain will be scaled 1-10. Nurses will scale pain and then will evaluate the effectiveness of the pain medication. This will be documented on the med sheet. Residents with pain issues will have pertinent information documented in the nurse's notes. If pain med ordered is not effective, the doctor will be notified for new orders.

F 441: Was staff in-serviced on hand washing prior to donning gloves as well as flowing glove removal?

F 441: Staff were in-serviced on the policy of glove use. The policy states hands are to be washed prior to glove donning as well as after gloves are removed and discarded.

HFA/RN

Signature and Title

3-8-2011

Date